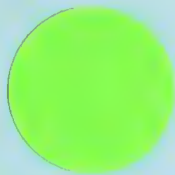


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Twelfth Annual Conference of State Medicaid Directors

Management Improvement Under Fiscal Limitations

May 12-15, 1980
Memphis, Tennessee

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Health Care Financing Administration

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THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) was established to combine health financing and quality assurance programs into a single agency. HCFA is responsible for the Medicare program, Federal participation in the Medicaid program, the Professional Standards Review program and a variety of other health care quality assurance programs.

The mission of the Health Care Financing Administration is to promote the timely delivery of appropriate, quality health care to its beneficiaries - approximately 47 million of the nation's aged, disabled and poor. The Agency must also ensure that program beneficiaries are aware of the services for which they are eligible, that those services are accessible and of high quality and that Agency policies and actions promote efficiency and quality within the total health care delivery system.

THE MEDICAID/MEDICARE MANAGEMENT INSTITUTE (M/MMI), within the Health Care Financing Administration, Bureau of Program Operations, works with Federal, State, and contractor staff toward improved management of the Medicaid and Medicare programs.

The M/MMI promotes program management improvements through problem analysis and technical assistance for corrective action, and fosters exchange of ideas and techniques through conferences, workshops, training and publications.

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MANAGEMENT IMPROVEMENT
UNDER FISCAL LIMITATIONS

Conference Report

May 12-15, 1980
Memphis, Tennessee

The Medicaid/Medicare Management Institute
Health Care Financing Administration
Department of Health and Human Services

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HEALTH CARE FINANCING ADMINISTRATION
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PREFACE

Representatives from HCFA's Central Office, several HHS Washington offices, the Public Health Service, the National Institute of Mental Health, the U. S. Justice Department, all HCFA Regional Offices, 43 States, the District of Columbia, Puerto Rico, and 56 private sector organizations attended the Twelfth Annual Conference of State Medicaid Directors. Two hundred and seventy four people participated in this four day conference which was developed and conducted by HCFA's Medicaid/Medicare Management Institute May 12-15, 1980, in Memphis, Tennessee.

The conference explored ways of improving the management of the Medicaid program while continuing to operate under today's and tomorrow's fiscal restraints. The conference agenda provided an opportunity for State Title XIX directors, Federal staff, public officials, and other program involved individuals to address problems and issues in the Medicaid program, to discuss future initiatives and directions, and to work together toward management improvements. The format of the conference was a combination of plenary and concurrent work group discussions that offered a forum for an intensive exchange of ideas, concerns, and expertise in selected program areas. The agenda included subject areas suggested by the States and Federal staff.

During his keynote speech, former HCFA Administrator Leonard Schaeffer stressed that program managers responsible for coping with the fiscal restraints and rising costs under which we are forced to operate must find ways to cut costs while preserving services for those in need. He also emphasized the need to improve the Federal/State relationship by involving States in Federal decisions through the Federal regulatory process and State participation in Technical Advisory Groups (TAGs).

Conference presentations stimulated interest and reactions and the topics covered were pertinent, comprehensive, and generated enthusiasm for further formal and informal discussions. Some of the topics discussed included MMIS, PSROs, Medicaid Reform, Federal/State Relationships, Medicaid Quality Control and Program Validation, and a report on the State Medicaid Directors' Council meeting. Exclusive of Federal moderators, there were a total of 47 speakers and panelists representing 13 States, the Federal government, and five non-government organizations.

In their evaluation, registered participants agreed about the productivity of the conference which provided opportunities to learn about relevant Medicaid problem areas and to share experiences among and between States, HCFA central and regional office staff, other Federal agencies, and the private sector, regarding methods and opportunities for improving Medicaid operations within present and future fiscal restraints.

This report is a compilation of the plenary sessions, a summarized agenda, summary reports of the concurrent work group discussions, and includes a list of participants.

SUMMARIZED AGENDA

MANAGEMENT IMPROVEMENT UNDER FISCAL LIMITATIONS

May 12-15, 1980

<u>TOPIC</u>	<u>SPEAKER/PANEL</u>
Welcome	MARY S. KENESSON Former Director, Medicaid/Medicare Management Institute (M/MMI) Bureau of Program Operations (BPO) HCFA Baltimore, Maryland VIRGINIA M. SMYTH Regional Administrator Region IV/HCFA Atlanta, Georgia BEN C. CRIM Director, Bureau of Medicaid Administration and Coordination Department of Public Health Nashville, Tennessee
Medicaid Goals for 1980 and Beyond (Talking Points)	LEONARD SCHAEFFER Former Administrator, HCFA Baltimore, Maryland

CONCURRENT WORKSHOPS

Improving Services to Beneficiaries	BARNEY SELLERS, Moderator Director, Office of Beneficiary Services HCFA Baltimore, Maryland PATRICIA SCHOENI Former Director Office of Public Affairs HCFA Washington, D.C. DAVID F. CHAVKIN Managing Attorney National Health Law Program Washington, D.C. PETER M. BLOOMSBURGH Administrator, Medical Assistance Program Illinois Department of Public Aid Springfield, Illinois
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TOPIC

SPEAKER/PANEL

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TOPIC

SPEAKER/PANEL

Medicaid HMO Initiatives

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PLENARY SESSIONS

Update on Federal
Legislation and Court
Cases Impacting Title XIX

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TOPIC

SPEAKER/PANEL

Medicaid Quality Control
and Program Validation

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JOHN BERRY

Medicare Contractors'
Conference Highlights
and Medicaid Operating
Framework

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TOPIC

SPEAKER/PANEL

Medicaid Reform

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CONCURRENT WORKSHOPS

Fiscal Agent Procurement
Process

LAMONT M. WILLIAMSON, Moderator

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JIM PIRKLE
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Atlanta, Georgia

IRVIN ROBINSON
Director, Division of Procurement
OPA/BPO/HCFA
Baltimore, Maryland

<u>TOPIC</u>	<u>SPEAKER/PANEL</u>
Fiscal Agent Procurement Process (continued)	ED KIRSH Planning Officer, MSA Montgomery, Alabama
State Assessments/Performance Standards	JOHN JANSACK, Moderator NEWTON H. DIKOFF Director, Division of Standards OSPE/BPO/HCFA Baltimore, Maryland RICHARD L. MORRIS PETER M. BLOOMSBURGH
PSROs	JOYCE SOMSAK, Moderator Director, Division of Program Operations Office of Professional Standards Review Organization Health Standards and Quality Bureau/HCFA Baltimore, Maryland ALLEN DOBSON, Ph.D. Director, Division of Beneficiary Studies Office of Research, Demonstrations and Statistics (ORDS)/HCFA Baltimore, Maryland PAUL B. OSBORNE Executive Director Kentucky Peer Review Organization Louisville, Kentucky PAUL M. ALLEN
LTC Initiatives	TERA S. YOUNGER, Moderator Acting Deputy Director/BPO/HCFA Baltimore, Maryland Formerly Deputy Regional Administrator Region I/HCFA Boston, Massachusetts GEORGE GREENBERG Program Analyst, Division of Long Term Care Policy Office of Assistant Secretary for Planning and Evaluation Office of the Secretary/HHS Washington, D.C. JACK KNOWLTON Director, Division of Medical Assistance Program State Department of Social Services Albany, New York ROBERT A. STREIMER

TOPIC

SPEAKER/PANEL

PLENARY SESSIONS

State Directors' Report

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Information Systems in the
80's; Diagnosis and Procedure
Coding Systems

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Closing Remarks

MILDRED L. TYSSOWSKI

MEDICAID GOALS FOR 1980
AND BEYOND

TALKING POINTS

Leonard Schaeffer
Former Administrator
HCFA
Baltimore, Maryland

INTRODUCTION

- o It is a pleasure to be here today to discuss an issue that concerns all of us -- the public financing of health care.
- o States are responsible for the day to day administration of Medicaid and HCFA welcomes this chance to discuss and share ideas with you.
 - Operating an adequate Medicaid program in a time of rising costs and severe fiscal restraints is difficult -- and concerns both of us.
 - It is even more difficult because of a rate of inflation that is outstripping the government's ability to fund health programs.
- o Fiscal 1981, Federal Medicaid expenditures are estimated to total \$15.7 billion.
 - In many States, Medicaid represents the largest single item in the State's budget.
- o Although HCFA is accountable to the Secretary of HHS (Health and Human Services) and Congress for how these funds are expended -- we must rely on others to carry these programs out.
 - This means that we must have good working relationships with States and contractors.

STATE-FEDERAL RELATIONSHIP

- o One aspect that makes Medicaid unique is the relationship between Federal and State governments in administering this program.
 - This partnership can also cause some problems and misunderstandings.
- o I believe that the complexity of the Medicaid law reflects our country's basic confusion over the question of what is government's responsibility for helping poor people -- the ongoing public policy debate is most obvious in regard to cash payments.
- o Congress, by law, left many of the tough Medicaid decisions up to the States.
 - But it is up to the Federal government to make sure the States comply with the goals and process requirements of the program.
 - This kind of balance does not make for the best kind of relationship -- to put it mildly.

- o HCFA wants to improve that relationship.
 - We need the States' help and ideas.
 - We do not want to rely on what are basically negative tools (disallowances, compliance hearings, etc.) in order to achieve our joint goals.
 - We want to involve you in our decision making process.
- o There are various ways for you to get involved in helping us make policy.
- o The first way you can become involved in helping us is to actively participate in the regulations agenda.
 - We want all those affected by our deliberations to know in advance that regulations will be developed over a certain period.
 - The agenda allows affected and interested parties to comment and participate.
 - It is particularly important that States become active in commenting on various regulations.
- o The second way States can become involved in making decisions about the administration of Medicaid is to participate in the Technical Advisory Groups (TAGs).
 - Currently there are nine.
 1. Systems
 2. Surveillance and Utilization Review
 3. Management Information and Reporting
 4. Financial Management
 5. Program Standards and Evaluation
 6. Quality Control and Corrective Action
 7. Reimbursement Policy
 8. Eligibility Policy
 9. EPSDI

- o Additionally, I urge you to contact Dick Heim, the Director of the Office of Intergovernmental Affairs.
 - He has my ear; I see him frequently and I hold him responsible for keeping abreast of States' concerns.

CURRENT COST CONCERNS

- o However important our policy process may be, a major concern is the practical actions States may take to restrain costs and improve the operation of Medicaid.
- o Your objectives and our objectives are the same:
 - To focus limited resources on the purchase of needed services for eligible individuals.
 - To manage, rather than be managed by this large, complex, and difficult program.
- o Based on our knowledge of what is going on across the country, we have a number of suggestions to offer.
- o I have divided the actions States can take into two broad categories:
 - Those actions which produce immediate results
and
 - Those actions which produce results over a long period of time.
- o However, some actions which produce immediate results in terms of savings can have detrimental impacts on beneficiaries and on health care delivery systems.
- o When faced with growing financial constraints, many States' initial reaction is to resort to short term fixes which may relieve financial pressures on States but do so by shifting the burden to beneficiaries or providers.
- o These include:
 - Reducing the number of beneficiaries by adopting more restrictive eligibility standards.
 - Reducing or limiting services.
 - Reducing or freezing the dollars paid to providers, or requiring beneficiaries to share in costs.

- o These actions may produce cosmetic rather than real results.
 - Making eligibility standards more stringent may mean a larger number of uninsured poor go to hospitals unable to pay bills. Thus, the hospital bears the brunt of these cutbacks.
 - Hospitals may become financially troubled: Therefore, the State must rescue the hospital or it closes down.
- o Fortunately, there are more positive steps States can take.
- o The following actions can be cost effective in a short amount of time.

Third Party Recoveries

- Many Medicaid beneficiaries are eligible for payment by other third parties.
- By statute, Medicaid is the payor of last resort.
- States have been slow in setting up effective systems to recover these funds from other third party payors.
- To assist States in developing these systems, HCFA recently issued final regulations which will permit States to require assignment of rights to medical benefits as a condition of eligibility.
- I urge you to study this system.
- HCFA will provide technical assistance.
- o For example, the State of North Carolina, with six people and a budget of \$125,000 avoided costs of \$3.1 million and recovered \$2.7 million in FY 1979. In the first three quarters of FY 1980, North Carolina, with seven people and an annual budget of \$150,000, avoided costs of \$3.8 million and recovered \$2.9 million.
- o States which have been successful in operating third party recovery programs for a number of years include California, Michigan, Oklahoma, and Ohio.

Lock-In Programs

- Some States have implemented an administrative mechanism referred to as "lock-in."

- Requires beneficiaries to select a primary physician and pharmacy.
 - Services are reimbursed only if they are provided by these primary sources.
- o Missouri, Kentucky, and New Mexico have experienced positive results with this technique and have developed utilization review criteria for identifying potential lock-in candidates.

Innovative Purchasing Plans

- Volume purchasing -- particularly in the area of drugs.
 - MAC (Maximum Available Cost) for generic drugs -- has realized significant savings for certain States.
- o For example, Washington, Arkansas, and Alabama have contracted with suppliers of eyeglasses, medical supply items, or durable medical equipment to take advantage of the savings which can be obtained from bulk purchasing.

Second Surgical Opinions

- We are conducting a public information campaign to encourage people to obtain a second opinion before undergoing nonemergency surgery.
- We also have a national toll free hotline for referrals to qualified doctors.

Reducing Eligibility Errors

- Medicaid Quality Control System not only produces error rates but good analytical data to determine the causes of errors.
 - We are just beginning to analyze this data.
- o The State of New Hampshire has developed a very effective profiling system which enables it to focus on those cases which are error prone.
- o Georgia, Virginia, and West Virginia have also obtained good results with error prone profiling.
- o Wisconsin and Oklahoma are in the forefront in operating automated eligibility determination systems. Louisiana, New York, Delaware, and Maryland are developing similar systems.

- o The following actions I will discuss take more time to produce results.

HEALTH CARE INFORMATION SYSTEMS

- o Given the high volume of transactions in Medicaid, it makes sense to use automated data systems to facilitate the flow of information.
- o While I don't want to spend a whole lot of time on a very complex subject, suffice it to say that:
 - The systems for handling data and information typically meet only narrow needs of individual users.
 - These systems may be good for paying bills but they don't support good medical practice and may create incentives for bad medical practices.
 - In addition, when reviewed from a national perspective, the systems we use to process claims are incompatible.
 - Confounds communications
 - Contributes to inefficiencies and high costs
 - Makes it extremely difficult to analyze data and discover where money is being wasted.
- o The health care industry has not availed itself of the benefits of advanced technology because we have been unable to agree on standards for communication.
- o HCFA would like to act as a facilitator in developing these standards.
 - We want to work closely with States in developing these standards.
 - This kind of unified system should improve the timeliness and accuracy of benefits which, in turn, should help States save money.
 - We must have better information if we are to prove to Congress that the Medicaid program is working on a national basis and we must have data to support legislative changes in the future.

MMIS

- o Medicaid Management Information Systems is a step in this direction.

- o Congress recognized this need eight years ago when it encouraged States to develop and operate mechanized data systems known as "MMIS."
- o Unfortunately, in both the Federal and State governments, MMIS has been linked primarily to a claims payment system.
- o We are now developing, with your assistance, performance standards to evaluate how effectively States are using their MMIS for the overall management of Medicaid.
- o Except for States with small Medicaid populations in which a computerized system is impractical, all other States are in various stages of planning or developing a MMIS.
- o If I were limited to one suggestion, I would choose the effective development and efficient operation of MMIS as the single most important activity which a State could undertake because most other management improvement and cost containment activities are dependent upon it.

HMOs

- o Another approach to containing costs and improving services is to develop new forms of delivering health care which contain incentives for both good care and cost control.
- o This form must involve physicians in cost control. Physicians make over 70% of the resource decisions.
- o We are experimenting with a number of options to encourage people to enroll in HMOs.
 - For instance, we are currently studying a way to encourage Medicaid beneficiaries to enroll in HMOs.
- o HCFA is intensifying its efforts in HMO development for Titles 18 and 19 through an education outreach program, technical assistance, and legislative efforts directed toward reform of the reimbursement system.
 - We want to encourage States to support HMO development.
 - We also want to provide incentives for other forms of efficient health care delivery -- such as: outpatient ambulatory physician services or home health care.

LONG TERM CARE

- o Of particular concern is how to care for an increasing number of aged.

- o Medicaid is a major purchaser of long term care services in this country.
- o HCFA is concerned about our ability and the States' ability to care for this population.
 - We currently have a number of initiatives underway.
- o HCFA and the Under Secretary of HHS have task forces studying alternatives to institutional long term care.
- o HHS is supporting several national long term care channeling demonstration programs.
- o Channeling demonstrations will soon be underway.
 - HHS will make available \$20.5 million to fund nine projects to help States develop links between programs, case management, and plans of care in order to meet individual needs.

EXISTING DEMONSTRATIONS

- o On Lok Senior Health Services in San Francisco provides a continuum of long term care services, including community and home based services.
 - This program also has contracts with a skilled nursing facility and a hospital to care for its clients.
 - Reimbursement is on a capitation basis -- testing the feasibility of the HMO concept for long term care services.
- o We support the Triage Project in Connecticut which provides elderly clients with coordinated services.
 - Patients enter the system at one point for comprehensive assessment, with subsequent care coordinated and individualized.
 - The project has the authority to reimburse for a wide range of health and social services.
- o We are also experimenting with waiving the three day hospitalization requirement for Medicare coverage of SNFs in Oregon and Massachusetts.
 - We hope to determine how the waiver of the three day requirement affects cost and utilization of hospital and SNF services under Medicare.
- o Of particular interest to you is the Wisconsin Quality Assurance Project:

- This project is testing experimental survey and certification procedures for nursing homes.
 - Its streamlined process has cut down survey time from 10 days to two.
 - The survey team works with homes to rectify any deficiencies that are found.
 - To date, there appears to be no difference between experimental and traditional surveys in detecting major noncompliance problems in nursing homes.
- o This problem of how to carefully look after the aged will become an increasingly important issue throughout this decade. We welcome innovative ideas from the States.
- We must come up with an answer.

CONCLUSION

- o I am aware of the States' problems in managing Medicaid when there is simply not enough money.
- o But remember that -- In spite of the deficiencies and problems of Medicaid, it has been critically important in helping the nation's poor.
- o Without this program -- as flawed as it may be -- many poor would have no health care.
- o I want to leave you with three thoughts:
 1. The challenge of the 80's -- use our programs to influence health care systems - not just pay bills.
 - We are among the biggest purchasers of the third largest industry in the United States.
 2. HCFA does have an approach.
 - We have been consistent.
 - It's in our policy papers.
 3. You can get involved -- Regulations/Papers/TAGS -- and have influence.
 - You must.
- o I look forward to working with you and your staffs toward our mutual goals:
 - Delivering high quality medical care to those most in need.

UPDATE ON FEDERAL LEGISLATION AND
COURT CASES IMPACTING TITLE XIX

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MR. MERRILL: I wish I could come to you with a very rosy picture of what is going on in the Congress right now with regard to the Medicaid program and other related issues. Usually in a presidential election year, you find a great deal of legislative activity and a number of bills being passed, often at the last moment, to provide Congressmen and women the opportunity to go home and tell their constituents all they have done during that year. However, I am not sure that this year will follow that pattern.

I think a little bit of the backdrop of what is going on now would be helpful. As you are all well aware, we are living in an era of high inflation, flat productivity, and a diminishing tax base, both on the Federal level and, as I am sure you are acutely aware, on the local and State levels. Within that context, the Congress is currently much more interested in passing legislation that will balance the budget and save money in individual programs. This can be done in two ways: program changes that are cost effective or cutting out benefits or programs. I think both are being used currently.

Last night, for instance, the Senate finished their deliberations on the budget resolution for this year and, as anticipated, they passed a budget resolution that will actually have a slight surplus in it. That surplus results from two things: first, greater revenues through the windfall profits tax and other increased tax revenues, and second, decreased costs through cuts in social programs. I'll hasten to add that while they cut social programs, the Senate had a great deal more money in their budget for defense than the House did. Draw your own conclusions -- although the House also tended to have the same kind of balance.

To go from a deficit of about \$30 billion to a balanced budget requires a fairly extreme set of measures by the Congress and, as I just indicated, some of that balancing was done through increased revenues, but a lot of it was done through decreased social programs as well. Within that environment, I don't think -- I don't want to be called a liar six months from now -- but I doubt very much that you will see any new movement in terms of expanded benefits or major new programs in the social service areas; in this case, Medicaid.

However, politics is continuing to play a role. For example, some candidates running for reelection are in tight races this year and, as a result, they want to go home to their district with something significant that they can show to their constituents. I doubt that you'll see that kind of movement in the Congress as a whole. But, on a committee level, particularly where these people are powerful in the committee structure, there is some movement.

A case in point is that, starting this week, the Senate Finance Committee will continue markup of their national health plan. Basically, this legislation provides increased catastrophic coverage for the general population. It may include some coverage of non-covered people under Medicaid, or insurance pooling to cover the working poor. This is a bill that I think right now is estimated to cost \$14 to \$16 billion. So, against this backdrop of saving money, you do have action in the Finance Committee that is going in the opposite direction.

My sense is that the Congress will not, in the end, act on this, and that we will not have national health insurance in any form this year. But it does have some spinoffs that I think can be potentially damaging.

Currently, there is a bill that started out in the House as a very private tax relief bill for a couple named Brian and Vera W. Hall. I don't know them; they're certainly an anonymous couple in the history of American politics. But, because the Senate can only report legislation out if the House has already taken action on it, the Senate has attached the Medicare-Medicaid amendments of 1979 and 1980 to that bill for the Halls; they will also probably attach CHAP to that bill, and their national health insurance plan, if they act on national health insurance. So, this anonymous couple could conceivably be the vehicle for a great deal of legislation.

What this means, though, is that while the national health plan is being deliberated, the changes in the Medicaid statute that were already deliberated by the Committee are held up because they will be in the same bill. In addition, the CHAP legislation -- which I think Senator Long would like to consider part of his overall national health insurance plan -- is also tied up in this bill. As a result, unless somebody decides to free CHAP or free these other Medicaid amendments from the bill, no action will be taken on them because they will be tied up with national health insurance.

So, taking a series of issues which range from some very minor technical amendments in the Medicare and Medicaid programs to the CHAP proposal, the fact that they are tied to the national health insurance plan will almost certainly preclude their passage. But while this is the situation in the Senate, the House did pass a CHAP bill, which I think you probably are all aware of, which was essentially based upon the administration's proposal. However, they amended it in three ways on the floor of the House, which I think could be detrimental to its potential passage.

One of the ways the House amended the CHAP bill was by adding a sunset provision, making it a limited time bill; after five years the bill would expire and there would be no more CHAP programs. This, I think, would make it difficult for you, as administrators of State programs, to plan for an ongoing program.

Second, they added what essentially amounts to a legislative veto. That is, the regulations that would be written to implement CHAP would be subject to legislative scrutiny and vote. The Executive Branch, I think rightfully so, is opposed to permitting the Legislative Branch to veto regulations related to legislation; it appears to be a clear violation of the separation of powers, where the Congress enacts and authorizes legislation, and the Federal government, or the Executive Branch, implements that legislation.

Third, they attached a provision dealing with abortion, which impacts directly on States. The amendment goes beyond Hyde in limits of what the States can do. And, as you all know, this is a controversial issue.

So, if you combine these three amendments tacked onto the bill, plus the fact that the Senate has not acted -- and the Senate action is tied up in the national health insurance proposal -- I think that passage of CHAP this year might be very difficult. I am sorry to provide a bleak picture, but I suspect that is what will happen.

Also, in the House, as part of the whole floor action on CHAP, there was another proposal brought up which, while directly relating to CHAP, I think could have broader implications for the future. It did not pass, but it did not lose by a great deal, and I think it is of some danger. Essentially, it

would have placed a cap on the CHAP program in terms of funds that could be expended. In other words, as opposed to maintaining the concept of an entitlement program, you would have an entitlement program with a cap, and once that dollar figure was met by an individual State, or by all the States and jurisdictions together, no more Federal funds would flow for the program.

While this only related to CHAP specifically, there is a movement afoot -- and I think this is indicative of it -- to do that kind of thing for the whole Medicaid program, where there would be some dollar limit on how much the Federal government could spend on the Medicaid program. It did not pass, but it did not lose by a great deal. Given the concern over budgets and given what appears to me to be somewhat of a cavalier attitude toward social programs, this kind of proposal has some potential in the future, particularly when you consider that, this year, the Administration came in for a \$2.3 billion supplemental for Fiscal Year 1980 for Medicaid. I think a request of this magnitude is the history of the program. That \$2.3 billion represented a significant concern to the Congress and I think they'll be looking for ways in the future to not allow that to happen, either by eliminating the borrowing authority, by not providing for supplementals, or by placing a cap on the program. I'm not saying it will necessarily happen, but there is some mood in Congress for that to occur.

The supplemental this year, has cleared the House. The Senate marked it up last week. They lowered it a little bit. Actually, the House leveled it to about \$2.2 billion, and I don't think there will be any problem -- at least, right now -- in terms of the supplemental getting through.

Attached to that supplemental, by the way, is a provision that is of interest to all of you, and that has to do with the payment of prior claims. You know that the Appropriations Committee last year, actually by mistake, passed a provision which limited payment to claims that were no more than a year old. I say "by mistake" because the original intention was to pass a two year limitation, with some grandfathering arrangements in it, but to the surprise of Senator Magnuson, the House receded to his position, while he thought there would be some debate on it, and the one year limitation passed.

The supplemental has a provision in it which would correct this. It would have a two year prior claims limitation. It would also provide for some grandfathering of claims before that. I think that the supplemental will probably be out soon. Hopefully, this adjustment in the prior claims limitation will correct what I think has led to some confusion and problems on the part of many States as well as the Federal government.

I want to mention just a couple of other things that I think are relevant to you.

I mentioned that the Senate bill, this Brian and Vera W. Hall private tax relief bill, called HR 934, has some provisions in it that were Medicaid amendments, as does the House bill, HR 4000. HR 934 is tied up right now on the national health insurance debate; HR 4000, while it has been reported out of both the Ways and Means and Commerce Committees in the House, is tied up with the Appropriations Committee in the House, which is not particularly interested in new spending legislation. I think HR 4000, which started out basically as a spending bill to expand certain benefits, has, instead, become basically a bill to tighten up the program. Whether the bill ever gets out of

the House and goes to the Senate, and there is some consideration of it, still remains to be seen. But the bill is there and I think it does contain some provisions that -- whether this year or next year -- might be enacted into law. I just want to quickly go through them.

First of all, while the bill includes a number of benefit expansions, there are a number of other provisions which will be of interest as well. For example, there is a transfer of assets provision which would give the State authority, where there was a transfer of assets, to collect payment for Medicaid benefits that were given as the result of somebody becoming eligible because of the transfer. The State would be able to collect those benefits back from the beneficiary of the transfer. In addition, the Federal government could hold the people liable for penalties where it could be proven that the transfer was knowingly and willfully made.

Secondly, there is an intermediate sanctions provision which would give both the Federal government and the States more authority in dealing with providers who were not in compliance with conditions of participation. Right now, basically you've got a binary situation where either you hold a provider out of compliance and terminate its agreement, or you ignore the violations and let it stay in the program. This provision would provide some intermediate sanctions where you would not have to take that extreme step of terminating the provider.

This provision would preclude that provider from being paid for future beneficiaries of the program until the provider is in full compliance. However, the beneficiaries already in that institution would not have to leave that institution.

Another provision, really two provisions, which affects both Medicare and Medicaid, has to do with reimbursing for swing beds and differential reimbursement rates. First, hospitals would be authorized to use some beds on a swing basis for the purpose of long term care. While they can do that now, this provision would give them the flexibility of using beds on a given day as either acute or long term care beds, and we would reimburse at different levels, depending upon the type of patient in that bed.

Secondly, in a hospital where a PSRO had determined that an individual was in need of acute care, but there were no long term care beds available in that community, this provision would permit the program to pay the hospital for that bed at a differential rate, namely the average skilled nursing rate in that State. While, technically, we are not supposed to be paying for those days, I think the reality is we're paying for a lot of acute care days where we have lower levels of care involved.

These two provisions are in HR 4000 and in the Senate bill.

Another provision would -- I think this is something you might be familiar with -- permit some kind of delay of draw down payment by the Federal government in paying under the Medicaid program, where the actual payment would not be made until the check was cashed and drawn down on. This provision is in HR 4000. The Senate bill has a provision basically to establish a checks paid letter of credit program. HR 4000 also provides for States to continue rate setting programs after the demonstration period has ended. In other words, in a State like Maryland, where a rate setting commission is now reaching its last year, the only way to continue that would be to come up with

some new demonstrations. This would permit continuation of rate setting type arrangements without requiring a new demonstration.

Let me briefly note a couple of other provisions. The bill would provide or mandate that nurse-midwife services be provided on the State level, although it is not clear regarding how this would be done, how payment would be made, and under what conditions.

Also, there is a provision which would permit income from Veterans' benefits, SSI, and Social Security benefits to be passed through when determining eligibility under the Medicaid program.

Those are essentially the important Medicaid provisions in that bill. In addition, there is one other bill that I want to mention which has now been reported by both houses, cleared conference, and probably in the next week or so will be passed and will be signed by the President, and that's the disability bill. Essentially, that bill would provide for some clarification of eligibility for the disabled where, if a disabled person goes back to work, he or she could remain in the Medicaid program. It would also establish a new eligibility category on a very limited basis, with only \$6 million in authorization, for the working disabled.

That is, essentially, what the Congress has been considering. I think the next couple of months will deal much more with budgets and appropriations and maybe with something coming out, at least from the Finance Committee, on national health insurance.

In conclusion, I do not think the next few months will show anything significant in terms of Congressional action related to Medicaid.

MR. DEL REAL: I'd like to take a few minutes to discuss some current outstanding litigation issues which affect various areas of the Medicaid program.

The first area that I would like to talk about involves the issue of deeming. I sat down with a couple of lawyers from my office and they told me all about deeming last week and, after they were finished, I recognized that there was no way in the world I could tell you what the law is as to deeming, but I'll start with some of the basics and tell you about three recent decisions that have been made in the area.

Deeming, as we know, is the process of including a certain amount of income of a financially responsible person -- which is generally a spouse or a parent -- in the calculation of the amount of income that an applicant or a recipient is considered to have for purposes of determining Medicaid eligibility.

There are, as we know, the so called SSI States and, in 1972, the 209(b) States. Most of the problems that have arisen with respect to deeming, at least in the recent past, seem to have involved the Section 209(b) States, and those are basically States that have elected the option of determining Medicaid eligibility based on criteria which existed in those States and which was in effect as of January 1, 1972.

The Department of HHS is currently under two court orders which require us to issue a regulation prohibiting the deeming of income in 209(b) States. One of those decisions was rendered by the District Court for the District of Columbia in 1978; the other one by the District Court in Utah in 1979. The States were notified of these orders, the proposed rule was published in November of 1979, and a final rule should be published shortly. Both of those decisions are now on appeal; neither one of those decisions has yet been heard at oral argument.

The district courts consistently have ruled against the positions taken by HCFA on the deeming issue. In fact, I think we've won very few. However, most recently, we've entered into a new phase of litigation in which the circuit courts have begun to speak about the issue of deeming, and they have spoken in contradictory language.

In the case of Norman versus St. Clair, a case in which HHS was a defendant and which involved the State of Mississippi, a 209(b) State, the Fifth Circuit, held that deeming was all right. However, when the court was confronted with the low levels which were protected for the needs of the responsible relative, the court went on to say that deeming had to be flexible; that is, the State could not use the automatic, strict 1972 standards in determining the realistic living needs of the person who was responsible.

Two days after Norman was decided, the Seventh Circuit reached a contrary result in Brown versus Stanton. The Seventh Circuit concluded that deeming was prohibited and reversed the District Court's holding that flexible deeming was acceptable. So, essentially, the two positions are totally inconsistent.

The third decision that involved deeming, the case of Herweg versus Ray, concerns an SSI State, Iowa. In this case, we had a rather bizarre situation in that the entire Eighth Circuit heard the case and decided to split, four to four, thereby affirming the District Court decision which had held that an SSI

State could deem indefinitely, not just for a maximum of six months, as HCFA regulations require. The court also held, however, that the question of deeming must be determined on a case by case basis and that, in making that determination, there must be a finding that the deemed income is, in fact, accessible to the Medicaid applicant or recipient.

As you can see from a discussion of these three cases, there is a split of authority in the Circuit Courts. The State of Indiana has already filed a petition for the Supreme Court to review the decision in Brown versus Stanton, and it is anticipated that a further petition for certiorari will be filed in the Norman case.

We hope that the Supreme Court will take these cases. We hope that, at that time, it will ultimately resolve the contradictory positions taken by the Circuit Courts on this very complex area.

Another area that has received some attention lately -- again in the Supreme Court -- involves the Town Court case, which was argued in November of 1979 and in which we expect a decision any day. In the Town Court case, the Commonwealth of Pennsylvania had challenged the holding of the Court of Appeals for the Third Circuit that Medicaid patients have a right to a pre-termination hearing before a nursing home becomes certified.

The Department of HHS felt that the creation by the court of this right was not grounded in statute or regulation and created a danger of distorting procedural due process and, more importantly, creating a great deal of headaches for the Medicaid program.

We also felt that, if affirmed, the decision might have serious adverse impact not only on the area of nursing home decertification but also on a number of human resources programs.

In addition to our quarrel with the legal reasoning used by the court -- that is, the Third Circuit in Town Court -- the Department also considered the practical problems that would result if the decision was affirmed.

Some of the questions that came up I'm sure you have thought of already, but among them are the following: who would hold this hearing if the patients are to have a pretermination hearing? The Medicaid patients are the responsibility of the Title XIX Single State agency; yet the surveys are performed by the State survey agency, often a separate entity.

What weight could be given to the patient's views in terms of the kinds of questions that arise respecting decertification, questions that are technical and complex, such as compliance with life safety codes, medical records or staff qualifications?

How are the patients to be consulted? Many of those patients have been adjudged incompetent. Would the responsible agency be required to secure representation for each of those patients?

How would the opinion of one patient be weighed against the opinion of another?

These are but a few of the practical problems which would arise if the Supreme Court were to affirm the Third Circuit decision in Town Court.

One point, however, is worth emphasizing. By seeking to have the Third Circuit opinion reversed, the Department is not opposing patients' rights in the nursing home certification process. We are in the midst of reworking both the conditions of participation for skilled nursing facilities and intermediate care facilities, which will soon be published as a Notice of Proposed Rulemaking. We are also in the process of drafting survey and certification regulations, which are now in the pre NPRM public hearing stage. We expect that when these regulatory changes are completed, patients' rights will be meaningfully enhanced.

However, were the Town Court decision to stand, both Federal and State officials charged with enforcing nursing home standards would be stymied by the practical problems just described. We expect resolution of this issue any day now.

A third area that has been subject to some litigation in the recent past has been the question involving nursing home reimbursement under Medicaid. While at one time this was a very actively litigated issue, the area of reasonable cost related reimbursement has remained relatively quiet for the last few years. Of the cases that remain active, however, the Alabama Nursing Home case is still probably the prime vehicle for the main issue that continues to affect the nursing home industry, the State and HCFA. That issue is the extent of HCFA's statutory responsibility to review State plan proposals.

In the Alabama case, the District Court held in our favor and, basically, concluded that HCFA's plan approval procedures were proper and that to require the State to develop analytical studies and objective statistical proof would defeat the flexibility that Congress was clearly interested in granting to the States. In light of this decision, we continue to strike a balance between permitting States ample discretion in designing reimbursement methodologies while honoring the responsibilities imposed by statute upon the Secretary to assure the adequacy of State plan proposals.

The Alabama case, however, is now on appeal. Should the court, on appeal, modify the existing HCFA policy, we will, of course, so notify you, so that we may make adjustments on a cooperative basis and with a minimum of misunderstanding. We should bear in mind, however, that despite the approval in the nursing home area, some cases involving hospital reimbursement have been viewed more critically by the courts and HCFA's efforts in assuring the acceptability of those proposals have been subject to some scrutiny.

The cases in question are basically three: the Massachusetts General case, the Obledo case, and the Toia case, arising in Massachusetts, California, and New York.

In Massachusetts General, the State of Massachusetts was allowed by the First Circuit to establish ceilings on reimbursements for inpatient hospital services. The court also found that a prospective per diem rate, based on the cost of both Medicaid and non-Medicaid patients, complied with the reasonable cost requirement.

In Obledo, basically the decision was the same -- ceilings allowed, and in determining the reasonable cost, you can look to both Medicaid and non-Medicaid patients. However, in Obledo, there was one further development. The court found in Obledo that HCFA had not really performed its statutory responsibility to review and approve the State plan. Basically, the facts

involved a submission by the State of a four paragraph plan, with an appendix attached, which, during the course of the litigation, HCFA was required to admit it had not reviewed. All that it had looked at was the four paragraph plan presented by the State. The court found that this was not sufficient to comply with the statutory requirement of review and approval of the plan by the Secretary.

The third case, the Toia case, is a decision by the United States District Court for the Southern District of New York, and involved the most thoroughgoing judicial examination of the Medicaid alternative hospital cost reimbursement system. In essence, the decision approved the use of ceilings but disapproved the State's plan on reimbursement of residents' and interns' costs, holding that, due to lack of appropriate documentation, HCFA's approval of that portion of the plan was arbitrary and capricious.

From these cases, I think we can learn the following: First, the courts have made it very clear that HCFA must assure a well documented, contemporaneous record of its decision in approving a State plan. Because of this, HCFA has been taking a closer look at those alternative plans that have been submitted, to assure that a supportable basis exists for the essential elements of the plan.

The courts have also affirmed the ceilings and the prospective rate systems. However, the opinions seem to suggest that, in the future, review is going to be much stricter and that, to the extent that there is an appeals process within the States, it is more likely that the plan will pass judicial scrutiny.

One area that has received a great deal of notoriety in the recent past is the area of abortions. Basically, the involvement of the Department is with respect to the question of whether or not Federal funding of abortions should be subject to appropriations restrictions, which were enacted by Congress. The Federal government's involvement in the case -- there are two of them, the McRae case and the Zbaraz case -- has been primarily to defend the constitutionality of Congress' decision not to fund, under the Medicaid program, certain classes of medically necessary abortions.

I'd like to give you a little background as to the manner in which the McRae case developed.

Prior to October 1, 1976, there were no restrictions on the Department's funding for abortions under the Medicaid program. However, beginning with the HEW Labor Appropriations Act for Fiscal Year 1977, Congress has included in all HHS appropriations acts provisions that prohibit the use of funds for some abortions that can be considered medically necessary.

The first of these restrictions was for Fiscal Year 1977 when Federal funding was limited to abortions where the life of the mother would be endangered if the fetus was carried to term. This restriction continued until November of 1977.

The second version was in effect from December 1, 1977, through fiscal 1979, and it allowed Federal funding for abortions where the life of the mother would be endangered, for the victims of rape or incest when the incident had been promptly reported, and where two physicians determined that the woman would suffer severe and long lasting physical health damage if the pregnancy were carried to term.

The third version, which is the one in effect for fiscal year 1980, limits Federal funding to abortions necessary to save the life of the mother and in cases of promptly reported rape or incest.

From their inception, the appropriations have been the subject of litigation. On the very first day that the appropriation restriction came into effect, October 1, 1976, a series of lawsuits challenging that restriction were filed; among those suits was *McRae*.

In *McRae*, the plaintiffs were a class comprised of pregnant Medicaid beneficiaries who were seeking to terminate their pregnancies but whose lives would not be endangered by taking the pregnancy to term. The plaintiffs alleged that the appropriations restriction was unconstitutional. The District Court agreed. A preliminary injunction was entered, prohibiting the Department from implementing the appropriations restriction. That injunction was lifted in August 1977, after *McRae* was remanded to the District Court for additional consideration based upon the Supreme Court's decisions in two other cases, *Maier* and *Beal*.

In January of this year, the District Court again found the appropriations restrictions to violate the U.S. Constitution, to the extent that they restrict Federal funding of medically necessary abortions. We again appealed that decision to the Supreme Court.

The second case, which again was recently argued before the Supreme Court, was the *Zbaras* case filed in December of 1977, where plaintiffs alleged that an Illinois statute that prohibited the State from using any funds to pay for abortions, except in life endangering circumstances, violated both the Medicaid Act and the United States Constitution. We were not originally a party to that case, but intervened solely for the purpose of defending the constitutionality of the appropriations restriction.

The District Court found the appropriations restriction unconstitutional. Like the District Court in *McRae*, the District Court in *Zbaras* found that there was no legitimate governmental interest to support a legislative determination that favored the protection of potential life over the health of the pregnant woman. As was the case with the *McRae* decision, the United States appealed the *Zbaras* decision directly to the Supreme Court.

In each case, we essentially have argued that the Constitution does not prohibit Congress from making public funds available for childbirth related services, while at the same time restricting public funds solely to abortions performed in the most compelling of circumstances.

As I stated earlier, *Zbaras* and *McRae* were recently argued, and we are awaiting a decision on those cases.

The final subject that I have to discuss is the question of the MAC regulations. While the American Medical Association case is almost three years old, it still stands as the benchmark for all MAC litigation.

In the American Medical Association case, the court concluded that the term "reasonable costs", insofar as it applied to drugs, clearly embodied the congressional intent to prevent reimbursement for excessively priced medical items and services. The court believed that the MAC regulations were consistent with the reasonable cost standards because they endeavored to reim-

burse not costs actually incurred but rather those actual costs, less excessive and unnecessary costs.

Aside from issues concerning the statutory basis of the MAC program, there are two others that still continue to be litigated in this area. Specifically, the MAC program is being challenged as constituting an unlawful interference with the practice of medicine. It is also being challenged as unlawful price fixing. I would like to tell you what our position has been with respect to those two arguments.

As to the first argument, we have countered by saying that the regulations do not involve an interference in the practice of medicine; that while they are clearly designed to encourage prescription of equally effective but less costly drugs, they do not require any physician to limit what he/she prescribes to those drugs. In short, if a physician believes, in their professional judgment, that a patient requires a particular drug whose costs exceed the MAC limits, he/she may override MAC by simply certifying, in their own handwriting, that this drug is medically necessary for the patient. When that is done, the MAC limit does not apply.

We often hear that the physician certification requirement is so burdensome that it necessarily infringes upon the physician's freedom to practice medicine. As to this claim, we agree with Judge Marshall, who decided the AMA case, in stating that when requiring the doctor to identify, in writing, that the patient requires this type of prescription, the doctor is being placed in a position, "no more onerous than putting pen to paper as he already has to do in preparing the prescription itself".

The other challenge, involving the issue of price fixing, was raised in two cases, one in Arkansas and one in Maryland, where the pharmacists have argued that the MAC process is anticompetitive and that it does not permit the marketplace to really set the price. We believe that these arguments simply misperceive how the MAC regulations work. The essence of price fixing is that you sell at a price, or you don't sell at all.

In a price fixing situation, prices are imposed from above, artificially and arbitrarily, without permitting the marketplace to determine what that price should be. In our case, however, when the pharmaceutical reimbursement board establishes the lowest unit price at which a drug is widely and consistently available, it is not fixing the price, it is not arbitrarily imposing a price that it believes ought to be charged in the marketplace; rather what the board is doing is relying on already existing price structures and simply determining which price will assure ready availability of the drug at the assured levels of quality.

In other words, as to MAC, our position is that the government is acting as a prudent consumer and refusing to pay unnecessarily high prices for brand name drugs when the market already has equal quality generic products at a lower price.

This issue has recently been argued in the Arkansas case -- where we won -- and is currently before the U.S. Court of Appeals for the Eighth Circuit. We expect a ruling on that case shortly.

MR. CANNON: I appreciate this opportunity to discuss an antitrust problem that we at the Justice Department have encountered, what we call the Medicaid provider boycott. We recently addressed this problem in a suit we filed in South Carolina, United States versus South Carolina Health Care Association, Inc.

I will discuss this case in general terms in the hopes that I can give you some guidance, at least from an antitrust perspective, on how the case may impact on the relationship that you have with your providers. I want to alert you to the problem, as the Justice Department sees it, and ask you to call me if it arises in your State.

I hasten to add that the purpose of my remarks is not to focus attention on the South Carolina Medicaid program nor on the nursing home industry in general; rather, these remarks are designed to be applicable to any State Medicaid program and any provider group, whether it be nursing homes, pharmacists, or physicians.

I also must add that as a staff attorney at the Justice Department, my responsibilities are to investigate, file, and try cases, and not to make policy pronouncements for the Justice Department. Thus, my purpose here is to inform you of what we have been doing that may affect you, and answer any questions you may have on this problem. Antitrust Division policy is, of course, set by the Attorney General of the United States, or the Assistant Attorney General in charge of the Antitrust Division.

In South Carolina we focused on certain alleged joint activities by nursing homes, through their trade association, the South Carolina Health Care Association. Specifically, the complaint alleged that two things were being done that violated the antitrust laws.

First, we said that the Association had acted as the agent of its members to negotiate and then to approve or disapprove Medicaid provider contracts.

Secondly, we alleged that the Association's member nursing homes had jointly refused to enter into provider contracts, except on terms and conditions that they had agreed upon among themselves.

One of the results of this activity, the complaint noted, was that the price that the State paid for Medicaid services in nursing homes had been increased. After several months of negotiation, the Justice Department and the Association reached agreement on what we call a consent decree, which ended the case. By settling the case in this manner and by not going to trial, neither the government nor the Association produced any evidence on the allegations that we made in the complaint, and the Association neither admitted nor denied the allegations. Rather, the consent decree simply sets forth what the two parties -- the Justice Department and the Association -- have agreed to as to what should be the conduct of the Association and its members in the future.

Specifically, the decree prohibits the Association and its members from doing a couple of things: First, the Association, as a whole or through a vehicle such as the Payment for Services Committee, cannot accept or reject provider contracts on behalf of its members. Secondly, the Association cannot promote any plan among its members under which nursing homes jointly agree to accept or reject provider contracts. As a corollary to this, the Association

also cannot promote any plan or agreement among its members whereby nursing homes jointly decide to withdraw, or threaten to withdraw from the program.

On the other hand, the decree does set out the proper role the Association and its members can play in the development of Medicaid provider contracts. Generally speaking, it certainly does not erect an "iron curtain" between the Association and its members or between the Association and State Medicaid programs. Thus, the Association can represent its members in any judicial or legal proceeding; the Association or its members can advocate or discuss with you or other executive or legislative bodies (whether State or Federal), any proposed changes in the Medicaid program; and, of course, the Association can disseminate to its members any type of factual information about the Medicaid program.

You may ask what the Justice Department thinks this consent decree achieves and why we entered into it. To briefly summarize, we feel that the decree, in setting forth the permissible conduct of the Association, assures that each nursing home's decision whether or not it will participate in the Medicaid program will be made independently by each home without agreements with other nursing homes as to what course to take.

For obvious reasons, I cannot delve into the factual details of the South Carolina case; at the same time, however, I realize that both the complaint and the consent decree are phrased in legal language that is not easily digested. My hope is that my remarks will give you an idea as to the type of provider activity that may constitute an antitrust violation. I say "may" constitute a violation, of course, because each situation has to be analyzed on its own facts.

Our concern is with the pressure placed upon you and your Medicaid program by groups of providers and their trade associations. Thus, we believe that providers violate the antitrust laws when they agree, among themselves, to collectively withdraw from the program, or agree to threaten to withdraw unless certain economic demands are met. Decisions whether to accept or reject a contract should be made by providers on an individual basis, rather than a group basis.

At this point, perhaps a hypothetical example will be helpful.

Let's say, for instance, that several representatives of the State pharmaceutical association come to you and say, "We are dissatisfied with the dispensing fee. We think it should be higher than it is." They tell you that at a recent meeting of the pharmaceutical association, a resolution was passed to the effect that all members would stop filling Medicaid prescriptions on a certain date if you refused to raise the fee.

In our opinion, this probably violates Section 1 of the Sherman Act. Of course, if the members of the association go further and actually terminate participation from the program and not fill prescriptions for Medicaid patients, the violation would be even clearer.

Let me emphasize that this is, of course, simply one example, and that any number of variations could take place. Suffice it to say, however, that whenever you feel pressured by providers about reimbursement issues, you should check legal counsel, and if necessary, call me or any other member of the Special Litigation Section in Washington to discuss the situation.

The point that I want to make is that, while provider input certainly may be helpful to your decisions about what reimbursement methods to utilize, economic pressure of this type by your providers certainly is not helpful. Your decision should be based on the merits of any given proposition and not on the fear of group pressure. It may be, of course, that a reimbursement plan is too low. As you know, however, there are lawful methods by which provider groups or individual providers can make this known to you.

We at the Antitrust Division want to help insure that you do not experience the type of problems that I've spoken of the last few minutes or, if you have experienced them, that it does not recur. I would suggest that if you have any additional questions, please call me in Washington ((202) 633-2836).

Questions?

QUESTION: Question for Mr. Merrill. On the subject of swing beds in hospitals, do you know, would those swing beds be available to any nursing home, prospective nursing home patient, or just for the acute care patients in that hospital needing beds in a nursing home?

MR. MERRILL: Let me make a distinction. The answer to the question is it would be available to any Medicare or Medicaid beneficiary in need of a skilled bed.

I mentioned two proposals. One was the swing bed proposal and the other was the differential reimbursement proposal. I am afraid they might have gotten mixed up.

The swing bed proposal essentially would permit a hospital to use, on an ad hoc basis, some of its beds for the purpose of nursing home patients. In other words, a bed does not have to be classified purely as an acute care bed. If that hospital, through the planning agency, gets a certificate of need indicating there is a need for nursing home beds in that community, they will be permitted to admit patients as long term care patients.

The differential reimbursement proposal is simply for patients already in that bed who need a lower level of care.

QUESTION: With reference to the boycott by special groups, we have devised many expressed and active boycotts in Rhode Island throughout the years. I'm interested in what is involved -- in other words, your department, I suppose, could get them to discontinue their plans for an actual boycott, but I'm interested in the penalty. What could you really do to this group? In other words, it's sometimes better preventive medicine by knowing what you are in for than simply to try to stop the boycott.

MR. CANNON: There is a wide range of remedies. Federal antitrust laws have both civil and criminal penalties. In South Carolina, we sued for injunctive relief, to simply prevent them from doing this in the future. However, in any particular situation -- the penalties could range anywhere from a criminal felony conviction to civil injunctive relief.

QUESTION: For Jeff Merrill. Jeff, we constantly hear conversations about long term care, about the fact that it's left out of the national health insurance plan. Almost every single issue that came up in the State Medicaid Directors' meeting yesterday dealt with long term care. Can you talk briefly

about the effort that your office has under way in that area and also what the timing is, and what kind of interaction you'll have with States?

MR. MERRILL: I would agree that this is an issue, and while everybody recognizes it, very little is done in terms of taking some specific action.

Let me start with the Department and then move down to HCFA.

The Department has a task force dealing solely with long term care. It is chaired by the Under Secretary, Nathan Stark. The purpose of that task force is to acknowledge the fact that long term care problems are not simply problems related to the Medicare and Medicaid programs -- in other words, problems solely of medical reimbursement mechanisms -- but that the problems transcend that and there is a good deal of activity within the rest of the Department of Health and Human Services in this area. The Title XX program, and the Older Americans Act, certainly play an important role.

One of the specific things the task force is doing, under the guidance of the Assistant Secretary for Planning and Evaluation, is to develop some combined demonstration projects, basically in the area of channeling, to look at how people can enter the long term care system, what resources are available in that system, and how those resources can best be brought to bear in terms of individual patients. These demonstrations tend to rely heavily on case management approaches. I think that, to some extent, those demonstrations will guide overall long term, departmental long term care policy.

Within HCFA, we have a great concern that what has happened over the last seven or eight years is that, as the benefits for long term care have started to expand, or have become more available, program expenditures have expanded a great deal. Just as a matter of interest, under Medicare, in the last five years, expenditures for home health benefits have expanded ninefold. They went from about \$110 million to almost a billion dollars. In the Medicaid area, as you all know, intermediate care benefits have expanded tremendously since 1972.

So we have great concerns that anything we do in the future has to be done with the understanding that we might be talking about creating large new programs. A seemingly small program change can turn out to be very significant.

There is a long term care policy group in HCFA which is chaired by the Deputy Administrator, Earl Collier. The policy staff in my office is very heavily involved in that group as are the HCFA bureaus. What they are trying to do is to, (a) look at some of the experiences from HCFA's demonstrations in the area of long term care; (b) look at the policies that exist now to see how they can be better utilized or changed to promote long term care benefits; and, (c) see what expansions are possible.

I think that we are going to proceed very slowly. I cannot give you a specific timetable. We are going to proceed very slowly because we are concerned that any changes will have tremendous monetary impact. And, as I mentioned earlier, those changes are not going to be widely welcomed by the Congress now, given their mood in terms of expenditures. Hopefully, as things start to coalesce a little more, we can start to involve the States and the Medicare fiscal agents in some of the process.

QUESTION: I'd like to ask Juan -- one of my concerns on the court ruling on the abortions was the very broad definition of "medical necessity", and I have visions of, because of that ruling, being forced to pay for all sorts of nose jobs, face lifts, etc. Has the Department looked at that as an offshoot of that ruling?

MR. DEL REAL: I think, to my knowledge, at this time, we're trying to see what will happen with the abortion issue before thinking of other things. We are disturbed about the broadness of the definition of "medically necessary". It would appear that all that is required, at this time, is for a doctor to say, "In this case, it's medically required." But beyond that, yes, the implications that would follow from that could affect many other areas.

MEDICAID QUALITY CONTROL
AND PROGRAM VALIDATION

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MR. KAPPERI: I would like to briefly lay out the principles and themes that guide all of our activities in the Bureau of Quality Control.

You already know from Mr. Schaeffer's remarks that all of HCFA is addressing itself to the problem of maintaining needed health care services for our beneficiaries in an era of ever tightening budget constraints. In the Bureau of Quality Control, we accept a particular responsibility in this regard. From the time of our inception, we directed our energies to identifying ways to control misspent program dollars so that those dollars would be conserved for necessary services to eligible individuals.

Some of our activities, such as Medicaid quality control, are very well known to you and they will be more fully developed by Don Nicholson and John Berry. They will also describe some new initiatives that their offices are involved in.

But we also hope to bring on line certain initiatives being explored in other parts of our bureau. In BQC, we also have Offices of Systems Analysis and Financial Analysis. While these offices are not as well staffed or developed at this point as Don's office and John's office, they are already developing or researching some broad based systematic and statistical techniques to drive our decisionmaking and better target our total efforts.

In Financial Analysis, among other things, we are developing large data bases, primarily from institutional cost reports, to identify the more likely sources of errant payments. Where possible, we're looking beyond hospital institutional data bases; we're now taking some real close looks at some of the long term care providers. One of the more exciting things we are planning in Systems Analysis involves the merging of Medicare and Medicaid payment tapes and developing techniques to produce concise outputs and identifying the more extreme incidents of misutilization. This effort, of course, involves full cooperation from the States. While this technique requires further development and, in fact, the approval of Congress -- which has delayed our efforts in this area -- we have already had some more limited success working with States, including the State of New Jersey. As a result of our working together, New Jersey is getting better results with its Medicaid Exception Reporting System (MERS).

While we have limited resources in the Office of Systems Analysis, we are anxious to work with additional interested States and will make available the results of our efforts, as soon as they are useful, to other States.

One of the major premises we follow in all our activities is that all organizations involved in Medicaid and Medicare administration -- and that includes, of course, other HCFA components, the States and contractors -- are equally interested in improving program quality as we are, and we want everyone to join us in this endeavor. We simply want better program management and we know you share that concern. We think that we have a particular responsibility to bring focus to the quality management or quality improvement efforts occurring throughout the HCFA system, but we fully recognize that greater progress will be made in joint or cooperative efforts and we will celebrate your successes as well as our own.

Having said some things about what we are trying to do, I would like to close with some things we are not trying to do.

We are not looking to make arbitrary cuts in services or by cut rate services. What we want to do is minimize misspent dollars, close loopholes, and remove abuses so that maximum dollars can be applied to buying needed health services. We fail equally if we don't pay a bill that should be paid as we do if we pay a bill that shouldn't be paid.

Finally, and very importantly, we do not intend to upstage, embarrass or bring adverse publicity to other organizations, including the States, in the pursuit of our activities. We have, quite frankly, encountered reticence and even suspicion in soliciting cooperative efforts. I would like to finish by assuring you that our only objective is program improvement, not publicity or any other gain at your expense.

MR. NICHOLSON: The agenda references our validation review initiatives as one of the things we are going to present. I want to talk about that, but before I do, I want to discuss some of our other activities in the Office of Program Validation over and above the validation review process, itself.

My office, for example, takes sanctions against individual health providers who have been found guilty of fraud or abuse. I don't have an exact number in front of me, but that total number is somewhere in the neighborhood of 160 to 175 practitioners, nursing homes, home health agencies, and hospitals, where there has been a conviction. On the basis of that conviction, because of law, we are required to expel those health providers from the program for a set period of time.

Where the provider has been convicted, the length of the suspension is really the critical decision that we have to make. It's rather automatic with regard to the expulsion process itself; they're convicted, we throw them out, and those cases aren't too tough. The tougher ones are the ones where we try to expel providers from the program based on abuse.

Here we have cases that fall, generally, in two categories: one, the category of false claims. What the practitioner or health provider has done is submit billings that shouldn't have been submitted and the claims were false. However, the evidence was not sufficient to allow us to secure a conviction. Nevertheless, we can follow an administrative remedy in those kinds of instances and expel providers from the program on the basis of filing false claims.

The other box that those situations fall into are situations where the provider is clearly providing inferior quality of care or is guilty of gross abuse through overutilization or unnecessary services. Those kinds of cases we normally receive on the basis of recommendations from PSROs.

So, the whole sanction process is the responsibility of my office and one that we're trying to put a lot more initiative into, particularly in those areas where we have providers who have filed false claims for which we have been unable to secure a conviction. This has been an area that has been somewhat frustrating for us. We know, for example, that in another agency within HHS, the Office of the Inspector General, there are several hundred cases pending where we believe there are indications of fraud involved on the basis of the practitioner's or provider's practices participating in Medicare or Medicaid. In spite of that, it's very difficult to get convictions and we know that a large percentage of those cases never will be convicted. What we want to do is to be able to obtain the documentation necessary to be able to expel selected providers from the program on the basis of false claims, even though we weren't able to secure a conviction.

The second area that we have responsibility for in the Office of Program Validation relates to our role to the regional offices in their role related to you. We're involved, alongside the Bureau of Program Operations, in doing a periodic assessment of State agency and contractor performance.

Our role in that area specifically relates to those areas that you have a responsibility for in the States, that, for lack of a better term, relate to program integrity: the application of the post payment review system, what is done by the State after the generation of the SURS reports, the field review

process, the process related to medical review, peer review, and the action taken to adjudicate those cases.

We play a role out of the central office in developing the standards and developing the review guides to determine whether or not States and contractors are meeting those standards. Then the people in the regional office go onsite to participate in the assessment activity.

We also receive statistical feedback regarding State and contractor level of activity in abuse control. Several of you may be familiar with reporting Forms HCFA 51 and 59. Those forms provide us with information on the numbers of reviews and investigations that are conducted and the overpayments that are identified as a result of reviews on individual providers. We collect that statistical information and forward it to the Secretary and keep a running total of what that activity looks like, both on the Medicare and Medicaid side of the house.

There are other activities. I don't want to cover the waterfront, but I did want to spend a little time talking about: (1) the sanctions activity, and (2) our role, through the regional offices, as it relates to the State agency in the assessment process.

There is a blue booklet entitled, "The Fiscal '80 Audit Plan". That plan was developed early last fall and finalized in February. It represents our intended activity in program validation for fiscal year 1980.

Program validation is a term that you may not be familiar with. I hope that most of you at least have heard of it. It's a process that was spawned in 1978 and was born out of a history of a lot of activities that were carried on, either in Medicare or Medicaid, that bear a relationship to the way that we defined the validation process.

There are three broad purposes to program validation: One is to identify and be able to adjudicate out individual provider situations of fraud and abuse practices engaged in by providers that result in inappropriate expenditures of Medicare or Medicaid dollars.

In addition, we are also working to discover deficiencies in operating procedures which cause money to be inappropriately paid under Medicare or Medicaid. The third thing we're trying with program validation is to determine whether or not the policy -- particularly the reimbursement policy -- we are operating under that governs the way we pay for certain kinds of Medicare or Medicaid services is contributing to inappropriate expenditures.

We have three types of validation reviews. One type called Aberrant Cost Studies (ACS), relates to the institutional provider. This review looks at a particular aspect of a provider's costs, whether it's drugs, inhalation therapy, nursing services, dietary, whatever. We look at that in relation to other providers' costs and select out those where there is an aberrancy. Where we find, for example, that there is a gross "blip" in, say, the drug area, we'll target in on that particular provider, looking specifically at what it is about the way the drugs are supplied to that institution that is causing the costs to be so much higher in that facility than they are in other facilities. Where we document problems relating to that area, or any other area that comes under review while we're looking at those individual providers, we'll try to work with the provider and the contractor to achieve

whatever corrective measures need to be taken to bring those statistics back in line..

The second kind of review we call Systematic Abuse Reviews (SARs), which relates to noninstitutional providers. We take a cluster of a particular provider type -- podiatrists, dentists, ambulance companies -- select out 10 to 20 of those particular kinds of providers, and do reviews to determine whether or not individual providers may be perpetrating a fraud, or whether or not there are situations of overutilization or other kinds of abuse that need to be addressed.

At the same time we're doing that, we'll be looking at the claims payment system; what is it about the State or the Medicare contractor systems that caused these payments to be out of line with regard to ambulance companies, dentists, etc. We also look at policies; what is it about the policies governing, for example, payment of ambulance services, that may need to be changed because of problems that were noted as a result of the review.

The third kind of Program Validation review we call Program Implementation Reviews (PIRs). This review does not zero in on individual providers, either institutional or noninstitutional. It looks at a particular program area -- durable medical equipment and the way that durable medical equipment is supplied through home health agencies or nursing homes; arranged for services, hospital based physicians, the list goes on -- that has to do with some aspect of program reimbursement. We'll study that area intently by going onsite into individual facilities to see what it is about the way that hospital based physicians, for example, work and operate and bill that is causing the money to be paid that is being paid. We would then ask ourselves the question, is this reasonable, is this what we ought to be doing in this particular area for reimbursement for these kinds of services.

I mentioned that we spawned the idea of program validation in 1978 and 1979. For the most part, during this period we were testing procedures and approaches. We are now, as a result of our 1979 experience, building more standardized approaches. We're writing an operations manual, which is in draft, and when it is released to the regions -- will be their bible for conducting validation reviews.

We have, so far, completed 28 program validation reviews of the various kinds that I discussed. The review is done, all the review comments, etc., have been solicited, and the report is final. As a result of those 28, we've identified \$11,821,090 of overpayments specific to individual providers, or dollars that would represent program savings, based on our estimates, if the review recommendations are implemented.

We have 79 reports that are in draft. We've done the review. We've put pen to paper. These 79 are out for comment. We haven't put them in final yet. On the basis of those draft reports, based on estimates, we've identified about \$32.5 million of overpayments. In addition, we have 78 reviews that are now in process.

One of the things that represent a problem for us, and those of you involved in activities similar to what I've described as program validation may have some of the same problems, is target selection. What makes Hospital A a better hospital to go into than Hospital B? Or, why is it that we should review ambulance services as opposed to drug services?

We're trying to develop a capacity, a national base of statistics, that will give us something comparable to your MARS reports, or other kinds of reports, that will reflect out areas where we think, in a particular State, for example, we might want to focus our review attention on ambulances or drugs or whatever. Targeting the area of the country that we want to go into and targeting and selecting out the individual providers that should be subjected to review is something that we feel needs considerable improvement in our validation process.

Another thing that we're worried about and requires considerable improvement -- we're working to try to improve that area now -- is in the area of peer review-medical review. So much of what we come up with in identifying problems related to practitioners are questions of overutilization, unnecessary services, and quality of care. We're not very good at being able to adjudicate those kinds of issues. We have to seek expert help. What we're working to build is a stronger relationship between the program validation activity and the PSRO review function, and many of our regional offices have already -- particularly New York -- developed a lot of that kind of relationship.

We need to have a better capacity, through the total application of the post payment review process, to come up with the right kinds of screens to be able to target and select out individual providers that should be reviewed. The Office of Systems Analysis, which is one of the other offices in the Bureau of Quality Control, is developing a lot of software and hardware capacity. Paid claims tapes are being requested from the States and from the contractors. We're using software applications against that data to be able to screen out individual providers in areas that we want to look at.

Another area that represents a problem for us, where we need considerable improvement, is in the area of sanctions. You identify these providers, do your review, and come up with a problem. You have to make sure that you have the capacity to be able to take some action, based on what those problems represent. This is an area, too, where we are working to build our capacity.

What I would encourage you to do, if you have the time, is to take a few minutes and go through, at least peruse, the fiscal 1980 validation plan. It not only lays out our intended activity for fiscal 1980, but it also gives a little more information in defining terms and describing the process and purpose underlying program validation.

We have already initiated our planning process for fiscal year 1981. We've asked each of the regional offices to submit to us, by the end of May, their ideas about what should be done in fiscal 1981 concerning program validation.

Each regional office has a Program Integrity Director. After you review the fiscal year 1980 audit plan, if you have thoughts about areas of activity that you're involved in that would lend themselves well to program validation, you should contact that individual listed for your particular region to discuss your ideas.

We will be publishing a fiscal 1981 audit plan sometime in September which will lay out our intended activity for fiscal 1981.

Beginning with the quarter ending June 30, we want to issue a quarterly listing which will identify each completed validation review and include a

little syllabus describing what that review represented and the results of that review. We will then identify the individual that should be contacted if anyone in a particular State or contractor wants the full report.

One of the main hopes that we have, with regard to program validation, is that, as a result of what we're doing and what we're learning while we're doing it -- because it is still new -- that the review protocol and the activities that are associated with the validation review process will translate into improved and increased activity on the part of States and Medicare contractors following similar kinds of review protocols. We would like very much to think of program validation as something that could be used in a partnership approach that could be copied by States, intermediaries, and carriers, where they feel that they have problems along the lines that we're looking at.

MR. BERRY: I want to make some general statements about quality control programs and share with you some of the future directions that we anticipate taking.

First of all, keeping in mind the environment that all of us are working in, the environment of limited dollars, we clearly feel the QC programs that we operate are here to conserve funds by assuring that funds that are spent are spent correctly. Specifically, by "correctly", we mean for an eligible beneficiary for a covered service, within allowable fee schedules or costs, and not a duplicate payment.

To carry out this responsibility, the Office of Quality Control Programs designs and operates several quality control operations.

In Medicare, we look at the cost report settlement process between the intermediaries and the providers. We examine the way the carriers pay claims to assure those claims are paid correctly.

In Medicaid, we look at eligibility, claims processing and third party liability recovery. We look at utilization control and, starting this July, we're going to bring up a new quality control program in EPSDT.

The next report on MQC findings on eligibility, claims processing and third parties, we anticipate coming out this August. This will report the error rates from the April to September 1979 period, and also compare that period with the previous July through December 1978 period.

Some things that we try and keep in mind about quality control -- and hope that you do, too -- QC is an expensive process. It costs a lot of money to run these QC programs. It also costs a lot of management time to resolve the issues that we bring up in quality control.

The outcomes of quality control are our choice because, after all, all QC does is produce data, and what we do with that data is up to us. We hope that the data is useful as a catalyst for program improvement, and have some evidence that it is doing that in several different settings.

I think, within HCFA, we've already surfaced a number of issues as an output of the quality control program. Some are pleasant, some are unpleasant, but they are all issues that I think need to be on the top of the table so we can get them resolved.

The issue of State plans being approved in error, errors in either your favor or our favor, I think is very much on top of the table because of quality control reviews.

The issue of State practices that don't conform to State plans or are not contained in State plans is very much on top of the table and has been raised by several States as a result of quality control findings.

The issue of who is liable for misspent money as a result of SSI eligibility determination by SSA is on top of the table because of some issues in QC.

These are not things that QC has exclusively found or certainly that QC is exclusively addressing, but they are examples of policy concerns that are

brought out on top for resolution as a result of running these quality control programs.

Looking at the corrective action plans that the regions have just submitted as a result of their discussions with you, you can see several common themes running through them as a result of analysis of quality control data; The establishment of specialized eligibility units for long term care, and are we properly following up on information on assets and asset accumulation; The issue of third party liability recovery: do we really know how much money is out there, and are we going to find some good tools to identify and recover it?

These are just some examples of the way QC data can be used, because, after all, the bottom line of quality control is corrective action for program improvement; that's why it's there.

The quality control programs aren't perfect -- and I'm not telling you anything that you don't know. I think it's a challenge to all of us to take a look at them to see what we can do to improve their usefulness.

Some of the immediate problems that we're taking a look at in my office on these programs: the issue of national uniformity. We are running these QC programs alike across all the regions and across all the States, so we've got comparable data.

We're republishing the instructions for the field reviewers. We're running a rather rigorous regional office assessment program where we look at the way our regions are running these QC programs, and this will spread out to the States. As instructed in the Federal Monitoring Guide, we'll be taking a look at the way the States actually operate QC to make sure that we are looking at the same things together and we're producing comparable data.

An issue that several States have brought up is the resolution of differences. I think we've got a rather clear appeal process in the QC manuals. I think we certainly have an obligation on our part to make sure that that appeal process is followed and the States get a prompt, clear, and full response to the concerns that they raise where we find differences as a result of the Federal rereview.

Another kind of a problem that we're working on is the time lag on the data. For this information to be useful, it's got to not only be sound but it's got to come out on a more real time basis.

I'm going to talk about MQC-II, which is just a convenient term for categorizing a number of improvements that we're going to make in the QC programs that are basically oriented toward speeding up the data flow, as well as reducing the labor intensity that is required to produce this information.

You can concentrate on the weaknesses of QC and make some interesting cases about it. I would suggest you can also concentrate on the value of the QC data for corrective action, and do something about it. I think we have every evidence that that's going on and we certainly want to encourage it.

As far as the future direction of the quality control program, one of our strengths is also a weakness. While you run a uniform national program that

gives you national data that is comparable, you lose something in the ability to target these programs, and we're concerned about that and are going to be working on that in the next few months. How can we better target quality control into high error rate situations and the high expenditure situations in the areas where expenditures are growing, at the same time how do we keep a national overview on what's happening?

We also want to look at a wider scope of the program with quality control. In Medicare, for example, next year we're going to add home health agencies and unaudited providers to the scope of the cost report evaluation program (CREP) review. We also plan on expanding the cost report evaluation program into Medicaid next year, for the first time, and take a look at the way that State agencies are handling their responsibility to settle provider cost reports, not only in settling the reports and looking at the validity of expenditures, but on the prompt recovery of any overpayment.

We think this is a valid thing to look at when you look at the cash flow in this area and the fact that it has never had a comprehensive examination like we hope to bring up. It looks to us like it's a reasonable thing to do in terms of workload, and that we can do this by looking at the same cost reports we're already looking at in Medicare. We're looking at an all Federal QC program here.

That's something we anticipate starting in FY 1981, and we'll be out, formally, to tell you more about that as we can get the formal instructions cleared, but I did want to let you know that we plan on bringing that up next year.

As I mentioned earlier about MQC-II, we've got an idea about how to simultaneously reduce labor intensity and provide the information on a more real time basis by separating the review of claims from the eligibility determination process. How we think this will work is we'd run the case based sample the same way and come up with the eligibility "yes" or "no" kind of decision, run the dollar computation out on the basis of a beneficiary profile, but then draw a separate sample of claims to do the claims processing review itself.

That means we wouldn't have to wait the four months to accumulate paid claims and it means that we could examine some things in the claims processing situation that we don't see now; for example, claims that are paid to people that are not on the eligibility file. We have some basis to think that there may be a substantial volume of dollars that is paid to people that are not on the eligibility file at all, and I think that's something that the States are as interested in looking at as we are. You can't see that with the present claims processing review.

We're pilot testing this concept now in California and hope to spread the pilot test to Mississippi, as well, and perhaps one other State, and make a decision on the separation of the review sometime this fall.

With respect to how it will reduce labor intensity, right now the number of claims that we have to look at -- and this is a manual review and a very labor intensive process -- is a factor in the number of paid claims that come out of the cases that we pull. We think we do a better job of basing the number of claims that we review on some statistical determination, and that with a separate sample of claims, we'll probably look at less claims than we

end up looking at now. The fewer claims that we look at, of course, the less labor needed to produce this information.

If this pilot test works out as well as we hope it will, and we make the decision this fall, we would start the MQC-II, the new review process, either with the April or September period next year, or the October to March period in FY 1982.

We've recently begun to work with the TAG groups that are established under the Council of State Medicaid Directors, and we'll share with them our thinking, as it becomes crystallized. I think you all can rest assured that the technical and substantive decisions that are made on quality control will be made not only with the input but, we hope, with the full participation of the States. After all, this is a State based quality control system and we want to make sure that it's useful to you in recognition of its cost.

In summary then, we think that our job is to produce sound data on a real time basis, and we hope, over the next few months, to reduce the cost of producing this data. We try and maintain an open ear to listening to the States' and our regional offices' concerns, and we're open minded as to other ways that we can do that, or any inputs that you can have into the quality control system.

I would stress to keep in mind the two flows of data that quality control produces. The system not only produces error rates but it produces a large volume of information that analyzes these error rates and can help us pin down where the errors may be and help us draw some conclusions about what we can do to lower the error rates in the Medicaid program.

MEDICARE CONTRACTORS' CONFERENCE
HIGHLIGHTS AND
MEDICAID OPERATING FRAMEWORK

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MRS. TYSSOWSKI: My assignment is to highlight the principal Medicaid initiatives, plans, and policies as outlined in the discussion paper entitled, "Operating Framework for HCFA Program Administration".

I've also been asked to give you an update on the integration projects, and to present an overview of the Medicare Contractors' Conference, which was held about two months ago in Dallas. You might ask why a report on the Medicare Contractors' Conference is appropriate for a meeting of State Medicaid Directors. As time moves on, it is becoming increasingly apparent that there is going to be a greater interaction between Medicare contractors and State Medicaid agencies. Because of that need for interaction, I think it's important that the Medicare contractors' staff and the Medicaid State staff become acquainted as individuals. Then we can understand each other's problems and objectives.

I realize that a lot is being done in that direction today. As we move toward implementation of these integration projects, there will be a need for considerably more interaction between Medicaid staffs and Medicare contractor personnel.

One good example of this need for interaction involves the steps we are taking to implement a common physician claims form. This form provides for some local variations in terms of the items on the form and that requires negotiation at the local level. It also requires interaction to decide how the printing will be financed and costs will be shared.

There are also ongoing negotiations between Medicare intermediaries and State people regarding the development of common audit agreements.

Those are just two examples of the need -- and I think it will be a growing need -- for considerable interaction between Medicaid and Medicare personnel. In HCFA, we view the regional offices as the principal catalysts in promoting this interaction at the local levels to implement various HCFA policies.

In an effort to recap the Medicare contractors' conference, we need to discuss the activity in the last couple of years to define where we should be going; i.e., the contractual framework within which the Medicare program operates.

There have been three major studies, one of which is sometimes referred to as the Rubel report, an inhouse study of HCFA's staff and departmental staff which was released in November 1978. Congress then asked GAO to make a study. They delivered a report in July 1979. The third and most recent report on the issue was the President's Management Improvement Council report, which was released in April of this year.

In addition to these studies, there have been experiments going on in the Medicare program to test the use of competition, to test the use of reimbursing contractors on other than a cost basis, and to test the impact of consolidating contractor territory.

To date, these experiments have only been in the Part B program. The proposed experiments in the Part A, or the hospital insurance program, and proposed experiments to combine administration of Parts A and B have been temporarily held up by court suits. The government has been challenged on the

ground that the statutory right of providers to nominate their intermediary supersedes the right of the Secretary to experiment. These court suits are now at the appellate level and until some decision is reached, those particular types of experiments will be held in abeyance.

The conference at Dallas afforded the Administrator of HCFA the opportunity to present proposals for a new operating framework for Medicare. These proposals have been fashioned out of these studies, out of experiments, and probably most importantly, out of almost 14 years of operating experience in the Medicare program.

At the Dallas conference, which was held on March 10th and 11th, there were representatives of virtually all the 119 Medicare contractors, and three of the subcontractors in data processing. We also had representation from the State Medicaid Council and, of course, Federal staff.

This was really the first time -- maybe some of you in the Medicaid program will be surprised to know -- there was a national conference of all Medicare contractors. We had had an earlier conference in 1976, but some of the Blue Cross plans were not present at that one.

The Dallas conference offered the Administrator the opportunity to set forth four basic elements of the Medicare contractor strategy, or the operating framework, which is set forth in this paper. Essentially, those four elements are: (1) we should proceed to establish standards of performance for the Medicare contractors; (2) we should select and award contracts through competition and reimburse on other than a cost basis; (3) we should combine into a single contractor the administration of Parts A and B, and (4) we should base contractor territory on geography and workload size.

Today, the Part B program is based on geography. The problem is in the Part A program where the territory or the jurisdiction of the intermediary is essentially based on the selection of the provider. In other words, on the institution.

You may notice in this paper that we have a model contractor territory which suggests 52 contractors instead of the present 119. This is just a model for discussion. It basically utilizes the State as a building block. However, in some States, there would be more than one contractor.

I'd like to mention here that we would be very much interested in the comments of the State Medicaid Directors on this proposal. We'd be interested in how you view this proposed change in Medicare administration insofar as how it affects your interface with the Medicare program. So, I'd like to encourage not only your comments on the Medicaid portion of the paper, but the Medicare portion as well. I think that the considerations to use the State as a building block and to combine the A and B programs were made, in part, to facilitate the working of Medicare and Medicaid programs at the local level.

I'd like to mention that this model cannot be achieved without legislation because the right of providers to nominate their intermediaries is a statutory right. Any attempts to base a configuration on geography would, of course, require legislation.

Now I'd like to talk about the Medicaid program section of this paper. Many of the directions for improvement in the Medicaid program are fairly

short range and many of them are incorporated in our work plans for fiscal year 1980.

Additionally, there are some longer range directions outlined and we are interested in your views as to whether the goals are realistic, whether they are attainable, and whether there are better ways to achieve them.

Essentially, the improvements that we have planned are designed to: (1) improve the accuracy and timeliness of payments for health care services, and, (2) increase the efficiency and cost effectiveness of Medicaid operations. The operational framework of the Medicaid program has been summarized here into five basic parts. Certainly a very major part is the MMIS; secondly, the performance measurement system; third, the financial management system; fourth, the State plans; and, last, the Federal/State consultation and assistance program.

A few highlights about the MMIS are: we have established, as a goal, that all States which now have approved APDs -- and that is all but eight of the smallest States -- should have a certified system in place by the end of calendar year 1982.

As of April 1980, 29 States had certified MMISs, and 17 States are in the process of implementing them. We'd be interested in whether you think such a goal is attainable for all the 17 States now in the process of implementing MMIS. I should mention to you, however, that there is a growing impatience with the time that it is taking us to implement MMIS. I think that is manifested in the Schweiker amendment, which I think you all commented on at your Orlando meeting. As you know, Schweiker was trying to put into statute certain time limits for the installation of MMIS.

I understand that this amendment may not pass, but I do think it is a manifestation of the Congressional concern. Also, Secretary Harris recently appeared before the Oversight Committee of the House Committee on Intergovernmental Affairs, where there was considerable pressure during the questioning regarding how soon we would get MMIS up, when we will have standards out, and so forth. So there is a lot of anxiety and interest at the top levels in government.

We're trying to work with you to keep these projects on track and to develop specific work plans as to when various deliverables should be completed in the installation of MMIS. We are also being a little more rigorous in our planning, and in the application and the providing of 90% funding. In other words, we are tying the 90% funding into both the completion and staying on target with established schedules.

Another aspect of MMIS that I'd like to briefly discuss is the MMIS umbrella regulation that was published on March 5, 1980. It became effective April 4th. This umbrella regulation permits us, through a notice process that you would have an opportunity to comment upon, to establish new requirements from year to year. Our immediate plans call for establishing, by September 30th, requirements and standards necessary for recertification.

Also, in that same notice, we plan to set forth certain new requirements for continued 75% funding. The one that is most likely to be included in the notice scheduled for September 30th would be the requirement to use ICD-9 CM for diagnostic coding.

At the same time, we would be issuing a proposed rule regarding the penalty provisions for a State that does not meet the established standards. In this connection, we would view fiscal year 1981 as a test period. While this notice on proposed penalties is being processed through the comment period, fiscal 1981 would be a year free of any reduction in 75% funding for failure to meet standards. Beginning fiscal 1982, we see the process in operation, and if an organization's system fails to meet the standards for recertification, they would be subject to loss of 75% funding.

At the same time, we are processing proposed legislation in the Department's fiscal 1981 package which would permit paying incentives or bonuses for superior performance. We're hopeful that this package will move forward and that, with legislative authority, we will be able to reward outstanding performance. Then, of course, States failing to meet the standards for recertification would be subject to a reduction in their 75% funding.

This leads to another principal element in the Medicaid operating framework: a performance measurement system.

The performance measurement system reflects two major efforts: one is the establishment of standards; the second is the development of information bases for measuring performance against these standards.

In your plenary session tomorrow morning, I note a session devoted to the standards for MMIS certification. I also notice that, in the afternoon, there is a workshop on State assessments. State assessments will be one of the primary sources for measuring whether a State is meeting the standards that have been established.

I won't discuss State assessments in depth; however, I would like to take note of a recommendation that was set forth at Orlando, in which you proposed that State assessments be performed every two years. In our response to you on those recommendations, we held to the position that we'd like to have them done once every year. We feel that in measuring performance against standards, and the State assessments are one of the primary sources of data, a two year span is too long a period of time.

Another element of the Medicaid operating framework is the financial management system.

In the financial management system, our improvements program is of two types. One relates to the interaction with the providers of health care, and there we have priority efforts in the area of common audits, the development of overpayment recovery systems, and validation reviews.

There is another kind of financial management that we want to give a very high priority to as far as improvements are concerned. That is the internal processes of budgeting, grant applications, and expenditure reports.

Much attention has been given in the past several months to Medicaid budget estimates. There has been attention in the Congress and in various echelons of the Executive Department, all basically in the course of defending a \$2.3 billion supplemental for Medicaid for fiscal year 1980 (an unprecedented supplemental in size), and a fiscal year 1981 appropriation request for Federal funds for the Medicaid program, amounting to \$15.8 billion.

In these discussions of Medicaid budget estimates, a few conclusions have been reached. One is that the appropriation estimate, this request for Federal appropriation, can best be developed on the basis of the estimates submitted by the State agencies, rather than by a national model.

For the past several years, we have been using a national model which takes in such factors as utilization of services, inflation, and changes in beneficiaries. Use of this national model has proved to be not as accurate as the summing of State estimates. Therefore, we have concluded that, at least for the immediate future, the base for the appropriation request will be the State estimates submitted in November.

Secondly, we have also concluded that if we are going to use the State estimates, we need a lot more data about the reasons for the changes from year to year. We need analytical data that we are not now getting. In other words, we need to be able to aggregate, on a national basis, the inflation factors that affect the total national estimate, or the changes in services or utilization that affect the national estimate.

Therefore, to meet the two basic conclusions that came out of this discussion of the Medicaid budget estimates, we are revising the Form OA-25.

While we will be asking for more analytical information, we will also be trying to reduce some of the paperwork burden for the estimating. For example, one area that we think will be fruitful in this respect is the combining of the OA-65 and the OA-25. We also are thinking about the possibility -- and I'm not sure whether we can do this within our existing authorities -- of moving towards an annual grant process.

Additionally, a financial management IAG is being established of State representatives. I can't emphasize enough that this is an area where we need your help to address this problem of getting the best Medicaid estimates. We also need a way of explaining to the Congress and to the OMB just what are the bases for the changes in estimates from year to year.

A fourth improvement area is one that relates to compliance with State plans. I think the whole compliance process has faltered due to a couple of factors: one, the procedure for processing a compliance is rather cumbersome, and, two, the penalties levied on a State are rather disproportionate to the compliance issue. In other words, you could be out of compliance in one area of outpatient services and you could lose all the Federal matching money for outpatient services.

We are trying to address this in two ways. First, in our fiscal year 1981 legislative package, there is a proposal that would give the Secretary authority to assess a smaller sanction. In the meantime, we are also examining the procedures for handling a compliance issue.

However, we are not going to wait for the enactment of legislation to act upon some of the compliance issues that are currently inhouse.

Also, I should mention that HCFA plans to study a selected group of State plans to determine the magnitude of erroneous approvals in the past.

A fifth, and last element in this improvement program involves our efforts toward improving the State-Federal consultation process and assist-

ance program. The two priority areas for technical assistance are: (1) assisting States on error profiling, and getting an MQC system underway; and (2) the processes involved in procuring fiscal agent software. We hope to be issuing guides in the latter area.

I understand that Mr. Schaeffer spent a considerable amount of time this morning talking about the consultation process and our need to work together on all these improvements. Therefore, I will not elaborate on that this afternoon.

I think the important thing is that we get intensive State input at an early stage in the development of policy and operational improvements.

I've briefly summarized what is in the Medicaid package, in the way of operational improvements, and the major thrust of the Medicare operating framework proposed changes.

Now I'd like to discuss the status of the most active integration projects at the present time. The first one is primarily active in the thought processes of some of us in the central office; the idea of a common fiscal agent for handling Medicaid and Medicare operations.

This project has limitations at the moment because of a hold on Medicare projects. In other words, if we are prohibited from combining Parts A and B in Medicare administration because of the provider nomination issue, any experiment combining Medicare and Medicaid administration would also be prohibited.

Hopefully, that hurdle will be overcome in time and we will have the authority to experiment with a common fiscal agent for Medicare and Medicaid. We are developing some recommendations to the Administrator on certain aspects of such a contract. For example, there is the question of whether you complete such a contract or take a fiscal agent that is now serving Medicare and Medicaid and negotiate a contract with such an existing organization. At the present time, there are 13 organizations which perform the Medicare work, or some Medicare and Medicaid work. You could say they are potential sources for negotiation, if you went the negotiation route.

Then, there is the question of who would be the project manager. And, if the Federal government is the project manager, what kinds of guarantees would the States want in the way of cost controls?

There are a lot of issues involved in getting such a project underway. And, right now, it's in the thinking stage as to how we might resolve some of those issues.

The next related integration project is a single organization for cross-over claims. This project involves a more narrow scope of having a single organization process crossover claims. It is felt that the Medicare contractor, since it is the first payor, is the logical organization to handle cross-over claims. You might want to protest that assumption, but that is the present basis for our planning.

We are interested in States and Medicare contractors who would be interested in getting together as candidates for a crossover project. We recently received a joint proposal from the South Carolina carrier and the State

Medicaid agency, and we are interested in getting a project underway, hopefully this summer. We aren't trying to demonstrate whether the idea is a good one. It is pretty much accepted that it makes sense for one organization to handle these claims. The thing that we're most interested in is working out the procedures. We also hope to work out the financial procedures so that a single check can be issued to the provider or to the beneficiary.

Another group of integration projects relate to common claims forms. We're making some progress in this area. The Administrator has approved the use of the AMA physicians' claim form, with some modifications, as a common claims form for the Medicare and Medicaid programs. Hopefully, other third party payors will also use this form. It will be numbered HCFA-1500. The Medicare contractors will switch to this new form as their supplies of the present Form 1490 are used up. We expect that to occur by January 1981. For the use of beneficiaries in the Medicare program, we have a simplified 1490 form.

We're hopeful that States will enter local arrangements on a voluntary basis with the Medicare contractor in the use of these forms. The issue as to what time would it be appropriate to make it a requirement of the MMIS system is still undecided. We need some more discussion with you on that issue.

We are not as far along on the form for hospitals; the UB-16. This is a form that the American Hospital Association developed with input from HCFA and other third party payors. It is now being tested in five States. The results of those tests should be evaluated by the end of this calendar year, and we are hopeful that in 1981 a decision can be made concerning the hospital form.

When I speak of these forms in the context of paper forms, I want to emphasize that we are interested in moving ahead with common tape formats. We're interested in moving rapidly towards a paperless society. Having common input requirements for Medicare and Medicaid would facilitate providers developing their own automated systems.

Another group of integration projects relate to common identifiers. Included in that category are the diagnostic and procedural codes. We have a decision on the ICD-9 CM. Our decision is that it should be CPI-4 based. We do have an experiment going on in South Carolina which would develop procedure codes for certain services that are not covered, like DME suppliers. It would also develop the methodology for converting existing codes to CPI-4 based. The evaluation for that project will probably be completed in a year.

We also have an inhouse project on common provider identification numbers.

I appreciate that there are other identifiers on claims that we really need to work on; e.g., beneficiaries, geographical locations, and others. Over time, we need to give attention to these areas.

Another area where I think we've made a lot of progress is the common audit and overpayment systems. We discussed that at some length in Orlando, so all I want to say now is that the common audit program is well underway. There is a possibility of 102 agreements between States and Medicare intermediaries. As you know, some States have more than one Medicare intermediary. That's why we have so many different agreements. Forty-one agreements have

been finalized. We have 42 agreements in draft stage, and the rest are under negotiation. I think we have made good progress with the agreements. I believe this program will be well underway in another year.

Questions?

QUESTION: Regarding the common claim form project, did I hear you say that there will be a nationwide Form 1500 that all carriers will use?

MRS. TYSSOWSKI: Yes.

QUESTION: Is there any flexibility built into that form for unique State requirements?

MRS. TYSSOWSKI: Yes, there is flexibility built in. There is a portion of that form set aside for elements that are peculiar to the Medicaid program. But you don't want it too flexible.

Bill, do you want to comment on this? Bill Hogsten, the head of our Office of Methods and Systems.

MR. HOGSTEN: The current draft of the form has built in six data elements that are unique to Medicaid. This assumes that the data elements that are common to both programs are already present in the form. And then there is a space provided in the form itself for those who need data elements that pertain to the States that are not covered in those six.

COMMENT: In a sense, what's happening is that there is a national form, which is being developed for Medicare. The suggestion is being made that it be used in Medicaid. Not having seen the form, I'm not sure how feasible that is, but my concern is that it may not be a useable form from the States' standpoint.

MRS. TYSSOWSKI: I think there has been State input into the decision-making on this form, and a lot of States are using it. Isn't that right, Bill?

MR. HOGSTEN: A number are using it. What we are doing now is distributing a copy of the package that we've developed, including the form, to the State systems technical advisory group for some discussion on whether we've met all the needs.

COMMENT: Bill and Millie both know that we have responded to the utilization of the nationwide form, and we have requested, in correspondence to Millie and to Mr. Schaeffer, that we withhold the utilization of that, nationwide, until we have some other information -- data elements, common identifiers, etc., more or less uniform around the nation, rather than go with that form.

We do recognize there are some problems with trying to utilize that form, and we have expressed that. However, Mr. Schaeffer has urged us to go ahead and utilize the form.

We've also expressed some concern about the new beneficiary form that is to be utilized for Medicare. We feel that would be a detriment to the assign-

ment ratio for the Medicare portion, but apparently the decision has been made to go ahead and utilize these, or at least mandate them on the Medicare portion and, hopefully, the States will be falling in line on these forms.

We have made some input into it, but apparently a decision has been made to go ahead.

MRS. TYSSOWSKI: As you say, the decision has been made to go ahead on the Medicare side. I think part of the concern that you raised, was whether we should try to resolve some of these other issues on the identifiers before we decide to use a common form. It's really a question of whether you wait to solve some of those other issues. Isn't that part of your problem, too?

COMMENT: What we recommended was, if we resolve those other issues, the common form would fall right into place, in uniformity of data elements, the descriptions, etc., place and type of service, all of the coding information. If we resolved most of those issues, then the common form, I think, would fall right in place. That's been our methodology for the input, and we would like to see those other projects be put to the forefront and the common form put back, so we can resolve those other issues.

MRS. TYSSOWSKI: I think that's one of the discussions we've had with you as to the priority of the ordering. However, I think we are also impressed that a lot of States are using the physicians' forms for the Medicaid program. I agree that it's a debatable issue.

QUESTION: Millie, I'm not sure I understood you correctly. I mean, in Pennsylvania, in the design of our system, we're basically using the physician form, and we have a form that the Blues and the Medicare and the Medicaid agencies are going to use, and it's basically the same form. In Pennsylvania, we could print that up and use it. You're not going to require the Medicare agency to use a form that you print and that has your number on it? I wasn't sure which it was going to be.

MRS. TYSSOWSKI: When the decision was made to proceed with that common form for Pennsylvania Medicare and Medicaid, we had not yet received a decision from the Administrator on the common claims forms. So, we went ahead and approved it, because you reach a point in your systems development where you're going to have to make a major call, and that's the call that was made. I think we are going to have to recognize that some of those decisions have been made, and that it would be some point in time, considerably in the future, that you would have any modification of that.

QUESTION: But your primary objective is, from the provider point of view, to make sure they're seeing the same form in Pennsylvania.

MRS. TYSSOWSKI: Right.

QUESTION: Then, if you try to do it from a provider point of view nationally, a common form, as long as States are building on that model, they can work towards the national form?

MRS. TYSSOWSKI: That's correct.

FEDERAL/STATE RELATIONSHIPS

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MR. HEIM: We heard an awful lot yesterday from various speakers about the environment in which we are presently operating, the difficulty of administering a very complicated program such as Medicaid.

Underscoring all this is the fact that Medicaid is a program which is a joint responsibility, both of the Federal government and the State governments. Several of the State speakers and Mr. Schaeffer were talking about the environment in which we must operate this program in the 1980s, an environment which has a slowing of economic growth, coupled with inflation, a demand by the public for better control of the programs, and the concern of the public that our programs are fraught with fraud, abuse, and waste. An increasing skepticism by the American public over whether large social programs, such as Medicaid, can be managed effectively.

Because the programs are so complicated, I think it gives rise to some of the tension and the conflicts which exist between the Federal and State governments.

Slightly less than a year ago, the Health Care Financing Administration was reorganized along functional lines to better meet the needs of this environment in which we are now operating. At that time, I assumed the role of Director of Intergovernmental Affairs in HCFA, as the ombudsman, the go-between, between the States and HCFA.

I would like to share with you just some general observations of some of the perceived problems on the part of HCFA administrators, both in the central office and in the region, and among some of the State officials with whom I have had quite a bit of contact.

I am just going to run over these things very quickly. This is not an exhaustive, complete list, and the specifics will be shared with you by the respective panel members.

I think, from the HCFA viewpoint, there is a strong feeling -- enunciated very articulately by Mr. Schaeffer yesterday -- that HCFA has to relate to the goals, objectives, and priorities set by the Administration and the Congress, which do not always see Medicaid as individual, unique State programs; and that the judgment of the success of the program is based on national results or, more often, the lack of results that we can pass on to them.

Among the problems that I think the Federal administrators see is the great diversity among the States, and the difficulty of writing national policies which will apply to all the States which are so very different politically, economically, geographically, and demographically.

HCFA administrators recognize the political realities at the State level and that State objectives usually are not the same as those that are set at the national level, and that States, indeed, have differing priorities.

They are aware of the fact that a common complaint from States is that HCFA doesn't listen to them. On the other side of the coin, there are people from HCFA raising the question, who speaks for the States: is it the governor, is it the legislature, is it the head of the single State agency, is it the Medicaid director, is it the head of the governor's budget shop, is it the program directors in the Medicaid program, or is it all of them or none of them?

I think, in summary, Federal administrators view the objectives of State officials as that of maximizing Federal dollars and minimizing Federal interference. On the State side, what I hear from State officials is that HCFA fails to recognize that States are unique, and that what may work in one section of the country will not work in another section; or that what may work in all the other 52 jurisdictions may not make sense in a particular State.

Other problems brought to our attention are unrealistic deadlines when States are expected to have a change in the program put into place, the lack of State involvement in policy decisions, inadequate technical assistance, the insensitivity to or lack of responsiveness of HCFA officials to State problems and concerns, and the perception on the part of State officials that HCFA's real objective is to minimize the Federal dollars and maximize Federal interference.

I rather suspect the truth lies somewhere in between. I think we all know that the reasons for these problems are complex, and some come right out of our Federal system of government which is really an intergovernmental system, the age old problem of Federal supremacy versus State sovereignty.

Some, indeed, are inherent in the programs, the very complicated programs we administer, such as Medicaid. The statutes themselves create ambiguous and overlapping areas of responsibility and accountability.

Some, however, are of our own making, both HCFA and the States, which do not involve issues of constitutional law or statutory authority and are within our control to remedy, or at least minimize.

We have asked the panel to address this latter issue. What are some of the problems that each person on the panel perceives and, more importantly, what are some of the suggestions the panelists can make, how we can, together, develop a more effective working relationship.

MR. ALLEN: I was a Fed for 28 years, and I have been a State type for nine years, so I have a lot of experience on both sides of Federal/State relations.

In this regard, I remember when I was a Fed and used to go out to the field from the central office, oftentimes they would introduce me with a statement to the effect, "He's from Washington, and he can't help you very much, but he sure can hurt you."

So, I keep reminding myself of that cliché because it is symptomatic of some of the attitudes that State people have about Federal people in Medicaid and vice versa.

My boss, Jack Dempsey, is the Chairman of the National Council of State Public Welfare Administrators under the APWA this year, and he wrote a letter to Stuart Eizenstat, Assistant to the President for Domestic Affairs and Policy, on March 11th.

In it, he highlighted several specifics with regard to overall Federal/State relations that, in part, are germane to our discussion here. Within that general rubric, there are similar problems in Federal/State relations in the Medicaid area.

The first issue that Jack put in the paper to Mr. Eizenstat was the issue of attitudes, and I will read directly the first sentence of the first paragraph. He said, "Put very simply, there are almost no persons in the Department of Health, Education, and Welfare who have much understanding of the character of the administration of public welfare programs."

In the Medicaid sense, we, as State directors, often feel that our Federal/State relations are hampered by the lack of knowledge and experience, at the Federal level, of what it means to be a Medicaid director and live in the environment we have to live in. That's the first point.

The second point he made was of most pressing concern in the welfare/Medicaid arena, the matter of fiscal sanctions through such processes as Medicaid quality control.

Another concern he spoke to -- and here we are getting down to the essence of some of our problems -- and that is -- the costs of ADC and Medicaid programs are shared by the State and Federal governments. This is a major contentious issue in that, unlike Medicare, which is 100% Federally funded, Medicaid is partially State funded -- in my State it is 50% funded by Michigan. Consequently, because Medicaid management directly involves the expenditure of State dollars, we have an intrinsic relationship in our administration of the program between local health and welfare issues.

These relationships concern themselves with service delivery and with the public's perception of a government program. Because Federal administrators are removed from community and local issues, it is very difficult in our Federal/State relations to bring about a mutual understanding so that we can work together to achieve what we think are common objectives.

Another issue that Jack addressed, concerns the continuing promise at the Federal level that there be a simplification of regulations and processes for the States' use in administration, and the fact that simplification doesn't

seem to be coming to pass. To the contrary, issuances and processes are getting more complex at the Federal level, and are being passed down the line to the States.

A further recurring theme is the lack of consistency between various parts of the Department of Health and Human Services.

There are agencies within HCFA right now, two or three that are handling the same issues, and it is difficult for us, at the State level, at times to feel that we are dealing with a unified organization.

I am not going to dwell further on some of the points in this letter, but I commend it to your attention. It is well written. It is not a harping criticism. It is not vindictive in any way, it highlights some of the issues, and, I think, it's the consensus of the States that Jack has articulated.

Undergirding the problem to us in Federal/State relations right now is the reorganization of HCFA that brought Medicaid and Medicare together. I think most of us agree it is a good idea. On the other hand, most of us feel that Medicare is the dominant managerial policy setting group, and that Medicaid, because of a lack of expertise at the HCFA level, is getting short shrift and will continue to do so unless the States continue their pressure to obtain a partnership and understanding of our problems. To Medicaid administrators, it is quite obvious that there are major differences between the two programs in terms of financing, in terms of service delivery, in terms of scope of benefits, in terms of public perception as to the value of these programs. And these differences make it very difficult to administer a program of this magnitude in a Federal/State partnership.

My budget is a little over 12% of the State's total budget. Last year it was bigger than ADC and direct relief combined. It's bigger than the education budget. And so we are very much in the limelight, and we need better Federal/State relations if we are ever going to eliminate, from the public's view and opinion, their dim outlook on the Medicaid mess.

In conclusion, I think that I have seen in the past couple of years a real effort by the Federal government to improve Federal/State relations, and I can't, in good conscience, offer any constructive ideas beyond those that have already been put on the table, and that is the greater use of State people in Federal technical advisory groups and in meetings like this.

As part of this continuing dialogue, I think it would help if we defined our mutual objectives and then worked on them collectively. I think the States have a great potential for supporting Federal Medicaid objectives through their Congressional delegations and through their governors.

We (HHS and the States) haven't explored this to the depth that we should, and I think, for the long term, there is a big payoff here for both of us.

MR. WILLIAMSON: I would like to open my remarks by saying that, personally, I favor the States. I am all for States, and I favor Federal/State relationships.

One of the things that has always impressed me about the Medicaid program is I think it really is an unusual and unique experience in Federal legislation. Fortunately, people like you and HCFA have reaped the benefit of being able to serve in that very unique experiment in Federal/State relations.

I think it's very much complicated by the fact that it addresses virtually all of the citizens in the country. It places burdens on States financially and administratively, and provides for Federal participation, both administratively and financially. But, I think in almost everybody's view, it leaves the great burden of administration to the States.

It's not a grant program in the sense that it's a block grant. And, I don't know what direction that NHI, in the future, will take in terms of restructuring the health insurance programs which are funded by the Federal government, funded by the State governments in part, but I wouldn't be surprised to see something different come down the pike over the next five or ten years.

Certainly, that is a possibility, and I think when you look at Federal/State programs and you look at some of the amendments and changes that were made with respect to those programs -- and I am thinking primarily of the SSI program -- you wonder about some of the decisions that were made in the Congress in terms of where is the best locus for effective administration of these programs.

So, my view of Medicaid, contrary to Medicare, is that it is a very, very difficult task for everybody. I think that everybody is working toward a common goal in terms of providing services to people who need them. I think we sometimes get caught up in our frustrations with respect to policy, procedure, new directions, initiatives, all kinds of pressures, which, in my view, and I think in the view of most of you, are certainly greater now than they have been in the last 10 or 15 years.

The impact of Congressional oversight, the impact of State legislatures, the impact of the General Accounting Office, and other reviews of these programs, is tremendous. I think that is triggering some of the things that HCFA is involved in, and that many of the States are involved in, in terms of change.

One of the things that impresses me very much is that with the reorganization of SRS, the reorganization of HCFA, and now the reorganization of the department, that there has been a substantial period of flux and change, I think, in the administration of the program over the past three or four years.

I think that, from the Federal standpoint, structural changes, and reorganizations -- Medicare and Medicaid are statutorily different programs that address common areas -- and organizational changes, regardless of what they are, are not going to make things work. It is people that are going to make things work.

I think the redesign of HCFA and the integration of HCFA is an effort to put in place a structure that can more effectively address these problems.

I also think in doing that, we have suffered. There has been some slippage in terms of the overall capability centrally, particularly in the Medicaid area. I guess some of you don't really realize what that meant to the people in the Medicaid Bureau, the shutting down of that Bureau, the shifting of that staff substantially to Baltimore, people who had life long careers in that area. There was substantial modification and change in staff and structure.

I think there is an excellent corps of people in all components of HCFA centrally. As a matter of fact, you would be surprised, but we have some State employees working for us. That is true. We have had some State employees transfer to HCFA, and we are getting a better influx of State people into the HCFA programs. As a matter of fact, I think we have some Federal employees who went to work for some States.

But we are getting somewhat of a mix and a change in terms of people. We have some outstanding, excellent administrators, who come to us from State governments directly out of responsible positions, who have an excellent perception of what some of the problems are.

I think, as we work along, that we will be able to serve you better, and we will be able to provide a basis for better dialogue with you.

Some of the things that were mentioned earlier, I think will contribute to that, and the better exchange with the Council. I am not sure that you are all aware of this effort that started at Orlando, which resulted in the creation of the State Medicaid Group, with representatives of the Council, Mr. Schaeffer, Millie Tyssowski, and others, who set up an ongoing dialogue, to meet quarterly, and to discuss issues and problems that are common to all of us.

One of the things that we will be doing in the future is utilizing more effectively these documents, like the discussion papers, the regulations agenda, and financial management.

I think there is a need in HCFA, and with the cooperation of the States, also, to do a more effective job of reviewing and updating the instructions, the procedures, the manuals, the policy documents, that are out in the States now.

I think we really have a challenge before us. I will just close by saying I noticed in the paper this morning that the President's effort to impose a 10 cent per gallon fee on gasoline, ran into trouble in the courts, and I understand the people over on the Hill probably are going to give him a hard time even to impose it. But I thought, maybe, if you all could go back and get your States to support that tax, and make it a directed tax to Medicaid State agencies, that we could probably get some real support for the program.

MR. PRESS: Since we share what, I feel, should be a State/Federal partnership, running the Title XIX program, we should do, on both sides, whatever we can do to better that relationship.

I chair, for the Council, the Program Integrity Committee. In that role I have become directly involved in a relationship, I guess one would call advisory, in terms of several parts of HCFA, in terms of both program and regulatory matters.

I consider that to be an excellent approach, as the whole idea of the technical advisory group is an excellent approach. I think it's one that the States support, and I think it's one that we will continue to support.

Obviously, it's a two edged sword. It's something we feel we can get input in, to try to insure that regulations and policies are not adopted which will be harmful to the programs that we run.

It should be pointed out, however, that, as a State person, it is clearly apparent to me that it's a weak partnership. We are at the weak end of the partnership. The Federal government clearly holds the upper hand and can make decisions as it wishes, or as it tries to, what one might say, get away with in certain circumstances. Our advice is not always sought out, and even when sought out, is not always taken.

I recognize that not every bit of advice that is offered should be taken under any circumstances. However, in a real partnership, a partner's advice is either warily or gratefully received. For a variety of reasons, this frequently doesn't happen in the Medicaid program.

On yesterday's agenda, there were at least two items of discussion -- EPSDT and a new physician's billing form -- which are examples of the kinds of problems that we have in terms of this Federal/State relationship.

EPSDT is now a program with unworkable regulations. It's a program that is very difficult for the States to operate, and the consequence of those regulations is probably going to mean, in some States, a lessening of their efforts. But the regulations and the program continue to move forward.

As regards the physician's billing form we heard about, we have a IAG involved, and, apparently, the IAG has specifically recommended against the form, or asked a variety of questions that haven't been answered, and the form is moving forward.

I just use these as examples of the kinds of problems we face, because decisions can be made regardless of what we feel is functional or good for the program.

From the State's point of view, as administrators of the program, we feel that we can better understand the pitfalls of regulations that are developed in Baltimore or Washington.

We know that each of us represents one of 53 different, unique jurisdictions. We have different programs, different problems, different approaches. We know that inflexible singular guidelines cannot solve all our problems and cannot regulate our programs, as they can Medicare. We are different.

We favor the carrot over the stick approach, and we believe that HCFA must listen to and understand our views if they want to meet their own goals and improve the program.

States must be allowed the flexibilities of their own approaches to particular problems, especially if their approaches can do a better job than the regulations, that are formed by HCFA, allow them to do.

Somehow communications must be improved. HCFA can help that by listening and communicating better. They can do this, first, by disseminating more information to the States on the best and worst practices of other States. That is why we get together, the Medicaid directors. We get together to listen to each other on our programs.

I mentioned yesterday, when I was listening to Don Nicholson talking about program validation, that one of the things that would be very valuable for us is to hear what is coming out of the program validation efforts, the MQC efforts, what is going on in other States, what is successful, what is unsuccessful.

Dick Heim, in preparing for this session yesterday, said that he sometimes felt he didn't know what the States wanted in terms of technical assistance. Well, more than anything else, I think we would like to know what other States are doing in just about every area, so we don't have to reinvent the wheel over and over again, so we can find out how somebody else is resolving a problem. Many of us communicate that way, almost on a constant basis, write back and forth, "What are you doing about this problem, what are you doing about that problem."

I still feel that that kind of communication has not occurred to any great extent.

Again, if we can take this kind of approach, both in terms of the TAG approach and the communication approach, I think that the Federal/State relationship should have nowhere else to go but up.

And I think it's important we do have common goals. It's important that we try to reach those goals together.

MR. BRYANT: Federal/State relations have been around in the Medicaid program since the inception of the program. In talking with you individually and in groups in Region III, I have not heard anything from the panel, so far, that is different. I think the concerns on the State side are well known to us. While the 1980s will be a period of dynamic change for the health care delivery system and the financing of health care, I do not expect the Federal structure of our government to change.

I think with that as a backdrop, we have to see the solution of this problem of Federal/State relations as one of mutual respect and concern for our individual jobs.

I am going to limit what I have to say from a regional standpoint, because in HCFA, half of the staff is located in the field.

The role of the regional office is changing in terms of its mission, as outlined by the Administrator. Most of our activity involves monitoring and assessing the State Medicaid programs a percentage of the time. Quality control effort, financial management, State assessment, etc., represent a fairly large portion of our staff assignments. In performing these activities, you run into disagreements and tensions.

One observation I have made from talking with other Regional Administrators is that contrary to what the States believe, regional staffs do recognize that there is a difference between Medicare and Medicaid.

I do not believe that we are trying to "Medicarize" the Medicaid program. But sometimes the States are unwilling to see the advantages that accrue to the total Medicare and Medicaid programs by the integration projects. We have to be flexible and recognize that we have to adapt integration projects to meet local needs, which we strive to do.

In the regional offices, we see great advantages to improving the effectiveness of our programs by integrating some of the paper processes and the red tape burden we place on the providers and our beneficiaries. We are striving to understand the States' problems and to work with States in finding solutions to those problems in a cooperative effort.

In talking with some of my peers about this short statement I am making, the one thing that came through with all of them was their concern about States, in working on individual problems, "shopping around" for answers. In terms of confidence and respect for each other's problems, in seeking out help from the regional office and trying to find solutions jointly, it does not facilitate the process if State Medicaid Directors "shop around" for answers if they do not like what the regional office has to say.

In conclusion, I would just like to say that there is a genuine effort on the part of regional staffs to work with the States to find common solutions in a constructive way.

There is no single panacea to this effort. It might sound simplistic, but I feel it is evident that the most important effort we can make to ensure we have a common understanding of what our goals are is to continually promote staff-to-staff meetings and discussions, sharing information and being totally up front with each other.

MEDICAID REFORM

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MR. KENYON: We are in the process of reforming the Medicaid program in the State of Florida. We are very excited about what we have been able to do to date, and we are very optimistic about our ability to do that.

I think before we talk about where we are going with the reform study and with the reform of Medicaid in Florida, it is important to get a little historical perspective on where we have been and what some of the issues have been.

As many of you will recall, the original goal of the 1965 implementing legislation for Medicaid was to provide comprehensive medical care to at least the categorically needy population. Medicaid expenditures in this country more than doubled between 1969 and 1973, and, in fact, by 1971, there were 24 States that were experiencing severe Medicaid deficits.

The newly proclaimed goal in 1972 was cost containment. Well, as you might suspect, numerous States approached the cost containment strategies in a variety of different ways. Florida Medicaid was no different than other Medicaid programs in the country at that time.

Florida Medicaid expenditures, for example, grew very rapidly, from \$43 million in 1970 to over \$344 million in 1979. During the same time span, the Medicaid eligible population, however, remained at about 5% of the State's total population.

Medicaid in Florida was really an anomaly in that the State population had grown by more than 31% as compared to a national average growth rate estimated to be at about 6.5%.

Approximately 90% of Florida's recent population growth was attributed directly to immigration, of which 40% were retirees. This influx of retirees, as you might suspect, had a dramatic impact on the State's Medicaid program.

For example, the elderly population received 45% of the expenditures in 1979, but they represented only 27% of the total Medicaid eligible recipients. Approximately 35% of our present expenditures will go to support long term care. Another 37% will go to support other forms of institutional care.

These percentages in Florida reflect the national trend that all of you are experiencing. I think it is very significant to note that over three fourths of Florida's Medicaid expenditure support services are for only 5% of the Medicaid eligible population, and I think to a very large degree that this disproportionate expenditure pattern indicates the extent of the historical deficiencies that we have had in Florida in terms of the programmatic and financial planning of the State's Medicaid program.

Florida Medicaid has traditionally been viewed as a financing mechanism -- and I think they have done a pretty poor job at that -- as opposed to a well planned program of services that are specifically designed to meet the needs of the recipient population that we are charged with.

In fact, in recent years, the Florida Medicaid program has been heavily criticized for a lack of service orientation, a lack of sufficient commitment to provider involvement, for cost containment strategies that have actually resulted in more expensive institutional forms of care that take precedence over primary and preventive care, and for the lack of funding strategies that actually maximize Federal financial participation.

These criticisms, in large part, resulted in the 1979 reorganization of the Medicaid program. Formerly, the Medicaid program was part of the Public Assistance Unit. Last year, we experienced a 50% increase in professional staffing, and we were established as a separate organizational entity within the Department.

That move on behalf of the legislature was accompanied by a mandate to perform a reform study that would serve as the basis for the 1981-1983 legislative budget requests.

We finally completed our analysis of the reform study, and we focused in on all aspects of the program, including a detailed analysis of every major programmatic issue and an indepth analysis of the reimbursement issues and strategies that we had employed in the past, and those that we thought had merit for the future.

In so doing, we relied, to a very large degree, upon systems directly from Region IV staff, particularly in the eligibility area, and upon expert assistance that we were able to obtain from our Medicaid Advisory Council.

We also looked very extensively at Medicaid expenditure data, service data, health care literature, State and national studies on health care issues, and selective components of other State Medicaid programs.

The resulting proposals of the Medicaid reform study clearly emphasize the complete reorientation of the Medicaid program in Florida, from being solely a funding mechanism to a program that provides for a continuum of care that is designed to meet the needs of the recipients.

As many of you know, Medicaid is a vendor payments program that is highly dependent upon the provision of health care by the private sector. Responsibility, as Mr. Schaeffer indicated, for the States to have a reimbursement system that is adequate is essential to assuring the availability of services to recipients in the State.

If the private providers do not choose to provide services to the Medicaid eligible population, then the recipients are all too often left with an empty entitlement to care. Too often this is exactly what has been happening in the State of Florida.

A major cause for nonparticipation among Medicaid providers in Florida has been low reimbursement rates. These reimbursement rates were cut under the cloak of cost containment in the mid-1970s. Cost containment strategies that were implemented were basically to keep reimbursements low, to limit the eligibility coverage to only the categorically needy, and to limit the service benefits to the mandated services, and provide for only a minimal number of optional services.

It is our view that these limitations may limit the services that are provided, but they do not necessarily provide for effective financial control. For example, in the State, our outpatient hospital services have been limited to \$500, and as a result, we feel that we forced inpatient hospital admissions.

We also have a \$50 cap on lab and X-ray services. What occurs is that those services are received, but they are provided in more expensive settings.

We also have extremely limited restrictions on our eligibility groups, which create fiscal pressures on local governments, on hospital taxing districts, and other sectors of the State.

The 45 day limit that we have on inpatient hospitalizations has the same effect. While limiting the service benefit, it actually causes increased expenditures by local agencies and other sectors of the State and local governments.

The use of eligibility and service limitations may appear attractive on the surface, but it doesn't assure the efficient and effective use of local and State funds for health care programs. Florida's health care costs for the categorically needy represent a very conservative program. In fact, Florida's expenditures are ranked 48th in terms of per capita expenditures among all States.

Another interesting point that we found in performing the reform study, was that the cost containment policy decisions that we had been implementing have greatly restricted Federal funds, and particularly funding for the medically indigent.

Ironically enough, Florida taxpayers are subsidizing the care of medically indigent persons in other States while deciding not to earn these dollars to support health care needs in the State of Florida.

Florida taxpayers have contributed very significantly, through the payment of Federal income taxes, to Federal revenue that supports these medically indigent programs in other States. In fact, Florida has the third highest ratio of all States of personal income to Federal Medicaid earnings.

What this means very simply is that Florida receives less in Title XIX funding per dollar of personal income than 47 other States.

We can't necessarily change Florida's tax burden overnight, but without a new perspective on the traditional cost containment strategies, the situation of fragmented, acute oriented care is only going to worsen. In fact, I think these comments very clearly convey to you that the policies that we have implemented have been unnecessarily expensive to the Florida taxpayers.

During the reform study, we contracted with Touche Ross and Company to determine the level of county effort being expended for the medically indigent that we might be able to bring under the program. Their results indicated that local governments spent \$119 million in fiscal year 1979 for indigent health care programs, without earning any Federal matching funds.

Unmatched local funds are spent in Florida for a number of reasons. One reason is the 45 day cap on inpatient hospital days that I mentioned. We determined that in Medicaid alone, with the current restricted eligibility groups, over 1,800 persons had capped out in fiscal year 1979.

We also determined that individuals requiring services in excess of the \$500 cap on outpatient hospital services were being picked up in some instances by local governments, and in other instances they weren't receiving the services.

We have also excluded from coverage, intact and unemployed parent families, and we severely limited the funding of community and mental health services. A few of these limitation effects we found include significant indigent health care needs that are simply not being met in Florida.

There is a lack of uniformity among indigent health care programs of those counties that have them. We have found, of the 67 counties, 55 actually had an indigent health care program, but they varied greatly in terms of the services they provided and the eligibility standards they had.

We found that unmatched State general revenue and county funds are used to support indigent health care unnecessarily, and other limited Federal funding sources, such as Title III and Title XX, are used to support indigent health care.

The total funding implications for a State such as ours, that has had in the past these very restricted eligibility standards, are significant. I think that all States in a situation similar to ours, might want to consider taking a look at what the implications would be of expanding their eligibility groups.

It became very evident to us that local governments are spending more money on health care than they need to. As a result, our reform strategies were really concentrated in three strategic areas.

One was to increase services, another to enlarge the eligibility groups, and a third was the development of a financing strategy that would treat Medicaid as the first payor among all local and State health care programs.

Right now, preparatory planning is underway to develop a financing strategy that will actually accommodate the recommendations that we proposed. What we are calling for is the pooling of local and State revenues that will actually maximize the Federal earnings. We have a very favorable matching ratio, favorable in our light anyway.

That will greatly assist us in being able to do this. But what we found was that the lack of a medically needy program in Florida was an unnecessarily expensive health care financing strategy. That is to say, that \$42 million of the \$119 million being spent by counties could be matched with Federal financial participation. This strategy would ideally only require \$28 million as match and, therefore, allow the State to return \$14 million to local governments.

We recognize that that is a very ideal situation, but we think it gives us sufficient flexibility to develop a financing formula that is politically acceptable to the urban, as well as the rural counties.

We are going to be working with representatives from local governments and other State agencies to develop a financing mechanism that is equitable to all the counties, which is related to the county's ability to pay, and founded on a financially progressive, as opposed to regressive, basis, that is based upon the County/State financial participation being in fixed proportions of total revenue, that is responsive to the escalating health care costs, and that is designed to maximize all available resources for indigent health care.

Switching gears just for a moment, one of the very important aspects of the reform study is our emphasis on the need to implement a Medicaid care continuum, beginning with primary and preventive care, and ending with community and institutional long term care services.

I am not going to review, or even attempt to review, all the aspects of that care continuum, but what I would like to do is focus for a few minutes on the long term care continuum. It has been a subject of much discussion in this conference.

One of our major efforts in the Department is deinstitutionalization, and if we are going to be able to do that and be successful like the State of Michigan -- who, I was astounded to find out, hadn't increased the number of long term care beds in over five years -- we are going to have to implement a number of services that we currently don't have, and also make some changes, very important changes, to those services that have served as alternatives to long term care.

One of the important additions that we feel is absolutely necessary is the implementation of adult day care services. We feel that this will allow many persons, who would otherwise require institutional care, to remain in the community.

In addition, we have recommended improvements in our home health program. We have called for a reimbursement rate increase for nurse and home health aides of 50%, and we have also recommended that agreements be developed with county health departments for home health nursing and personal care services, particularly in the underserved areas of the State.

Since only 36% of the State's licensed home health agencies currently serve Medicaid clients, the availability of home health services has been severely restricted. We simply have not been able to compete with the Medicare rates.

Yet, home health care in the State of Florida has been the major alternative the Medicaid program has to long term institutional care.

Another major element in improving Medicaid support of a continuum of care is the addition of community clinic services. Persons who are over the age of 65 represent about 17.5% of Florida's population.

This same age group comprises only 3% of the community health system's caseload. If you use national data, there is an estimated need in the State of Florida for mental health services by over 235,000 people. Yet, Florida's current community mental health system has a caseload of only 4,000 older persons.

As I have indicated, we feel that Medicaid reform must involve Medicaid funding of a wide range of services which support Medicaid recipients at any point along the long term care continuum.

If community services are not available in the State of Florida in the near future, what we are going to have is a State budgetary crisis. I think this is best evidenced by the fact that Medicaid expenditures for long term care have increased by over 226% in eight years, from a very meager beginning, by today's standards, of \$33.7 million, to over \$110 million in 1979, and we are forecasting about \$145 million this year.

By the year 1985, we expect long term care expenditures to be in excess of \$243 million, and by the year 2000 -- this has made a real hit with the Senate Appropriations Committee -- expect long term care expenditures to be in excess of \$1 billion in the State of Florida.

Close to 40% of Florida's Medicaid expenditures are now for nursing home care. The Title XIX eligibility process, that we have in place, itself seriously hampers a reduction in nursing home expenditures.

Medicaid's institutional bias in expenditures often results from obtaining eligibility through a spend down to impoverishment in institutional settings. Income eligibility in Florida's Institutional Care Program (ICP) in nursing homes is considerably higher than for those noninstitutionalized Medicaid recipients; \$566 as opposed to \$208 for a family of four.

So, many who qualify for Medicaid in an institution are ineligible while they reside in the community, and this is one of the major reasons that we are strongly supportive of the Pepper/Waxman legislation.

In recent years, funding of community care services for the elderly in the State of Florida has increased sharply. However, it continues to represent only a small fraction of the dollars that are expended on long term care.

The factors that have significantly contributed to this dramatic increase have been an increase in the nursing home caseloads, an increase in the facility reimbursement rates tied to the regulations, the growth in the chronically impaired elderly population in our State, the growth in the nursing home industry itself, and I think, most importantly, the lack of really viable alternatives to nursing home care in the Medicaid program.

In response to this, another major recommendation that we have called for is the implementation of a nursing home preadmission screening program patterned after that which the States of New York and Virginia have implemented.

Basically, the program will be designed to prevent unnecessary nursing home placements, identify the type of long term care services that are most suitable for the chronically impaired elderly population, and, lastly, to document the need for the community care services themselves.

We feel that this program will serve as more than a nursing home gate-keeping mechanism. It will also serve as an important linkage tool in the long term care continuum. The team will be composed of a physician, a nurse, and a social worker. They will be responsible for insuring that individuals are screened out of nursing home placement, and that such individuals will have their needs met in the community to the greatest extent possible.

It's going to be a very proactive kind of an arrangement where they will only approve nursing home placement if the services are not available in the community.

In other words, we view the preadmission screening program as the key to the development and implementation of appropriate placements in the State of Florida, and a very significant component if we are going to be successful in curbing the growth in long term care expenditures.

In total, there are 139 recommendations that we laid out in what we consider to be a very comprehensive and perhaps one of the more analytical studies that have been done in the Medicaid program in the State of Florida.

Ninety-eight of those 139 recommendations can be accomplished without additional resources. That was the fundamental tenet that we had in approaching the study, and we felt that we had to demonstrate to the legislature and to the public that significant improvements could be made before we could actually request additional resources.

We are proceeding on implementing all of the recommendations that we can within existing authority.

I have brought copies of the Executive Summary. I didn't bring copies of the full blown report. It was published in two volumes, and it is in excess of 800 pages. I would like to invite you to take a look at the Executive Summary, and if any of you are interested in getting a copy, I would be more than happy to provide it to you.

I would be interested in your views and comments. I think some of what we are proposing is contrary to what you all are experiencing right now, with the economy declining and the retrenchment philosophy that is probably pervading. But we have got a very different kind of situation in the State of Florida, and we are very excited about the future of the program.

MMIS

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MR. JANSACK: I would like to talk about, in a broad way, an overview of the performance standards, especially in the MMIS context, and tie it to the State assessment process. I will also describe briefly some of the upcoming activities in performance standards.

Essentially, of course, the major question is why performance standards. The answer is simple, Congress has provided an extra 25% FFP for implementation of MMIS systems. Congress, of course, expects a certain value for its dollars, and several years ago, had GAO see how MMIS systems were working.

GAO reported various problems. The primary finding was that some of the systems were not working as promised, even though they had been reviewed and certified.

GAO wanted HCFA to go back to the States and take another look at the actual operation of the systems to assure continued productivity and efficiency. GAO found problems with missing edits, they found problems with the Medicare/Medicaid data exchange, and they wanted to assure, again, that the value was being received.

The report, of course, came to the attention of both the States and HCFA, and a State TAG group began working to outline an ongoing certification process. I wish to emphasize that we have had a lot of contact with the TAG groups and appreciate their intense cooperation, their diligence and their hard work in providing us with the States' perspective on performance evaluation. You will hear later from the State people about how they have progressed in that regard.

What we are doing in performance standards we consider evolutionary. We hope to correct the mistakes that we make this year, next year, and, over time, have a reasonable and objective performance evaluation system.

Our objective is to have an up front presentation of what our expectations are for an effective operating system. That requires us, as described in a regulation published earlier this year, to let you know in advance what it is that we will be looking at, how we will be looking at it, and what the techniques are of our review process.

Another important feature is that the review system should be output oriented, and not process oriented. We want to look at how well the system is working, and not the particular specifications involved in the systems design. We will be looking to see that the edits are in operation, that duplicate checks are being picked up, and production efficiency will be realized.

At the present time, written procedures have been drafted and circulated to the States. That was the work of Newt Dikoff of the Bureau of Program Operations' Division of Standards and his people, together with, like I said, the considerable input of the standards TAG group.

We have had field tests in Michigan, and we are having another field test in Idaho to work out the bugs that we can see. We will be interested in your comments in the upcoming weeks and months as we revise that package.

Our goal is to have a package available for the regions to use in the review process by fiscal year 1981. The regulation published March 5, 1980, laid the groundwork and authority for issuing the new requirements before the

review period. The regulation provides that HCFA will describe new requirements it expects from an MMIS system, and after a certain period of time, it would be expected that the requirements have been incorporated into the State system.

Certainly, we hope to give the States a reasonable time to handle any changes of a significant nature.

In fiscal year 1981, we expect that the review instruction package will be used by the regions as they review your claims processing operations. The MMIS standards performance review package will be part of the State assessment process in the claims processing area.

One of the things we have tried to do is to assure consistency and objectivity from region to region. Therefore, the package has structured sampling procedures and techniques. Also, we are training the regions how to develop and utilize the samples. In that way, we hope to assure regional consistency and also fairness and objectivity to the States.

Samples will be taken as part of the State assessment. If there is a problem, there will be additional samplings for the remainder of the year to see, overall, what the performance level was.

The sampling techniques are based on statistical models developed by the Department of Defense, and are considered useful in evaluating claims processing operations.

1981 will then, in effect, be a full scale field test without any formal sanctions. The findings of the regional office will be part of the State assessment evaluation report.

The central office will revise the review instructions, based on the input from the States and the regions, and work with the ROs to assure, again, objectivity and consistency. One of our major objectives is to assure that the regions are synchronized and that the process is well coordinated and operates effectively and efficiently.

We also will be striving to identify relevant and pertinent standards, eliminate those items that are process oriented or minor or technical in nature.

Regulations will also be issued in fiscal year 1981 describing the reduction in FFP.

As a lawyer -- that's my background -- I have written many regulations. All of them have been challenged in Federal courts, and I noticed, a week ago, another decision at an appeal level that finally, I think, settled one issue. In this one case, five courts supported the regulation and five went the other way, but the appeal courts upheld that regulation.

The major point of interest about that regulation is that I worked on it in 1969 or 1970, so it took a few years to be thrashed out.

I expect somewhat less controversy with the MMIS regulation because of the efforts we made to talk to the States and the TAG group.

We have appreciated the input from the States. We will discuss more about the technical details in a later session, but I just wanted to give you the overview and especially the important contributions of the IAG.

MR. MILLER: I would like to thank HCFA for this opportunity to present to you some of the work that we, on the Systems Technical Advisory Group, have been doing in regard to the development of performance standards. However, what I think is perhaps more important is the development of a measurement methodology and the development of a flexible certification and assessment package.

Before we get into that, however, a few words about STAG and, more importantly, about a rotational policy which we have developed to ensure that we get input and representation from all the States throughout the life of STAG, which we did last December.

STAG was organized as the National Technical Advisory Group (NTAG) during the Albuquerque MMIS meeting in January, 1979. Our purpose was to provide a forum for the discussion of various HCFA initiatives that have some sort of a systems impact, primarily MMIS.

Figure 1 shows the States which were initially represented on NTAG: Georgia, Idaho, Michigan, New Jersey, Oklahoma, Pennsylvania, and Texas. In addition, the APWA Information Systems Committee and the State Medicaid Directors' Council were represented. The representatives of these two organizations are the liaison back to you and back to their respective organizations. They play a key role in getting input and information back out to you.

In December, we developed a rotational policy to assure that we get a good representation of States. We wrote to all heads of the single State agencies, to nominate people from their States to participate on what was then renamed as the Systems Technical Advisory Group (STAG) to come into line with the various technical advisory groups of HCFA.

The STAG chose representatives from those nominations at their next meeting, and we tried to follow several principles in that choice. We tried to maintain a geographic diversity; a diversity of large, medium, and small States; and some diversity between States which have inhouse processing and those which utilize fiscal agents.

I think we have been able to do that, and those are our intentions in the future. Our policy is that approximately half of the group will rotate off each year. The first year, three States rotated off. They were Michigan, New Jersey, and Texas. They were replaced by Montana, Nebraska, and New York.

I now want to get into the performance standards and the work we have been doing. Most of the materials that we are going to discuss today have been disseminated to the State Medicaid directors on at least two or three occasions: in a draft from last spring, in July when we sent our performance standard recommendations and measurement recommendations to Mr. Schaeffer, and then again in February, when we pulled this entire package together.

So, we hope that for many of you this is not absolutely new material, but I think it's important that we do discuss it. We are currently in an active dialogue with HCFA on many of these issues. I think you need to know what they are and to provide some of your input into them, because many of these issues have not yet been decided.

S-TAG REPRESENTATION



APWA INFORMATION SYSTEMS CMTE
STATE MEDICAID DIRECTORS COUNCIL

Figure 1

One of the first things we did was to decide that there cannot be a single set of standards. Our package divided the standards into two sets of standards; a set of performance standards which could be measured, and a set of functional standards which we felt were important to the operation of the program, but were not measurable. We feel this is an important distinction that we must have in any final package.

Figure 2 shows two areas of concern that we wanted to address. We wanted to be able to develop a package which would consider initial certification, and then also would be usable for periodic assessments. We also wanted it to be flexible. We didn't want to have a big problem to add, change, or delete a standard, and we wanted this package to adapt to various situations which might be found in future legislation.

Specifically, our package needed to be able to cover two types of funding which are shown in Figure 3. There could be constant funding, like we have today, or, as has been talked about a great deal, some sort of incremental funding. Within each of these, we have two cases again. We have the certification or assessment of the system as a whole, which is essentially what we have today, or we have some sort of logical grouping of certification or assessment, such as provider type, geographical area, or subsystem.

Under incremental funding, we wanted some sort of a sliding scale, so that rather than an all or nothing situation, dependent on your degree of attainment of the standards, you would get incremental funding between 50% and 75%. Our package even allows for incentive payments over the 75% level. Here again, the two cases of the system as a whole, by provider type, by geographical location, or by subsystem, must be considered. We think we have covered all of these bases, and we feel that this is a very important concept in the final package which has been promulgated by HCFA.

Our development methodology consisted of several steps which are depicted in Figure 4. Number one, you need an MMIS. Number two, we developed performance standards. Third, we developed measurement criteria regarding how to measure each of those standards. Finally, we put these together into a uniform, cohesive, flexible certification or assessment approach.

Let's take a little closer look at the measurement criteria which is shown in Figure 5. The key point on the measurement criteria -- and it's a very simple point, but one that's easily overlooked -- is that you should accumulate points based on how well you meet the standard. In other words, if you assign 100 points to the standard and you meet that standard, you will get all 100 points. If you only meet the standard 50% of the way, then you get 50 points. It is a simple rule, but it's something that we feel is absolutely essential in the development of the final package.

Figure 6 is an example of how we would apply this measurement criteria to one of our standards. Assume one of the standards is that 95% of the provider certifications must have been issued consistent with the State plan. The measurement criteria which we have outlined consists of three very simple steps: check the State policy, draw a sample of the providers, and check that sample against the State plan.

The critical part is how you award points for it. The measurement criteria that we have developed is a formula which will, in fact, award points, that if 95% of them have been met, they will get the full 100 points.

AREA OF CONCERN

- **INITIAL CERTIFICATION**

- **PERIODIC ASSESSMENT**

Figure 2

CERTIFICATION/ASSESSMENT APPROACHES

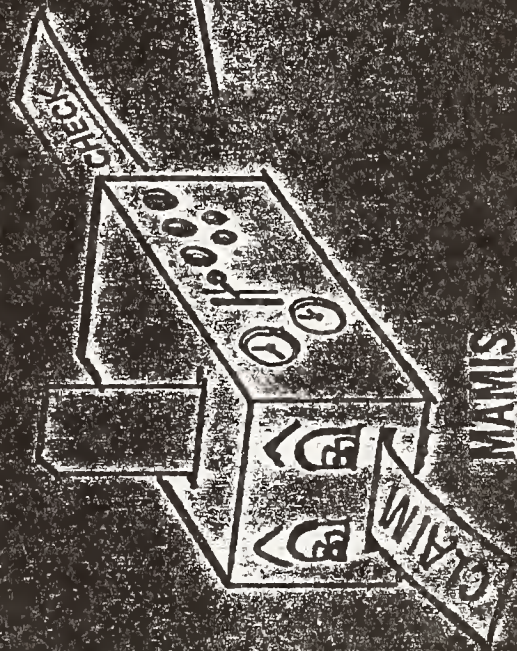
	<u>SINGLE ENTITY</u>	<u>LOGICAL GROUPING</u>
<u>CONSTANT FUNDING</u>	ENTIRE SYSTEM AT 75%	- PROVIDER TYPE - GEOGRAPHICAL AREA - SYSTEM - AT 75%
<u>INCREMENTAL FUNDING</u>	ENTIRE SYSTEM AT 50% - 75%	- PROVIDER TYPE - GEOGRAPHICAL AREA - SYSTEM - AT 50% - 75%

Figure 3

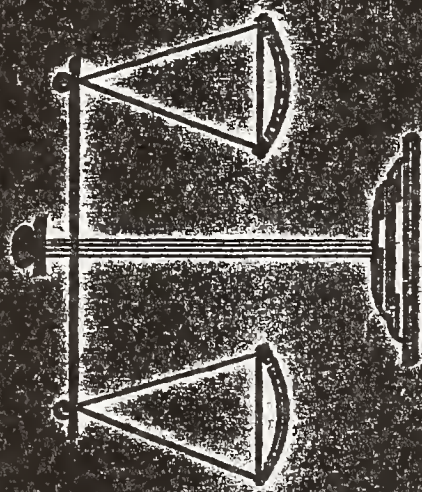


SYSTEMS
TECHNICAL ADVISORY
GROUP

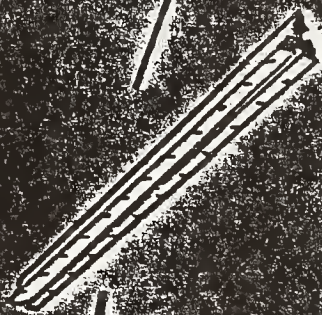
DEVELOPMENT METHODOLOGY



CLAIM



PERFORMANCE
STANDARDS



MEASUREMENT
CRITERIA



FEDERAL STATE

CERTIFICATION/
ASSESSMENT
APPROACH

Figure 4

PERFORMANCE STANDARD MEASUREMENT THEORY

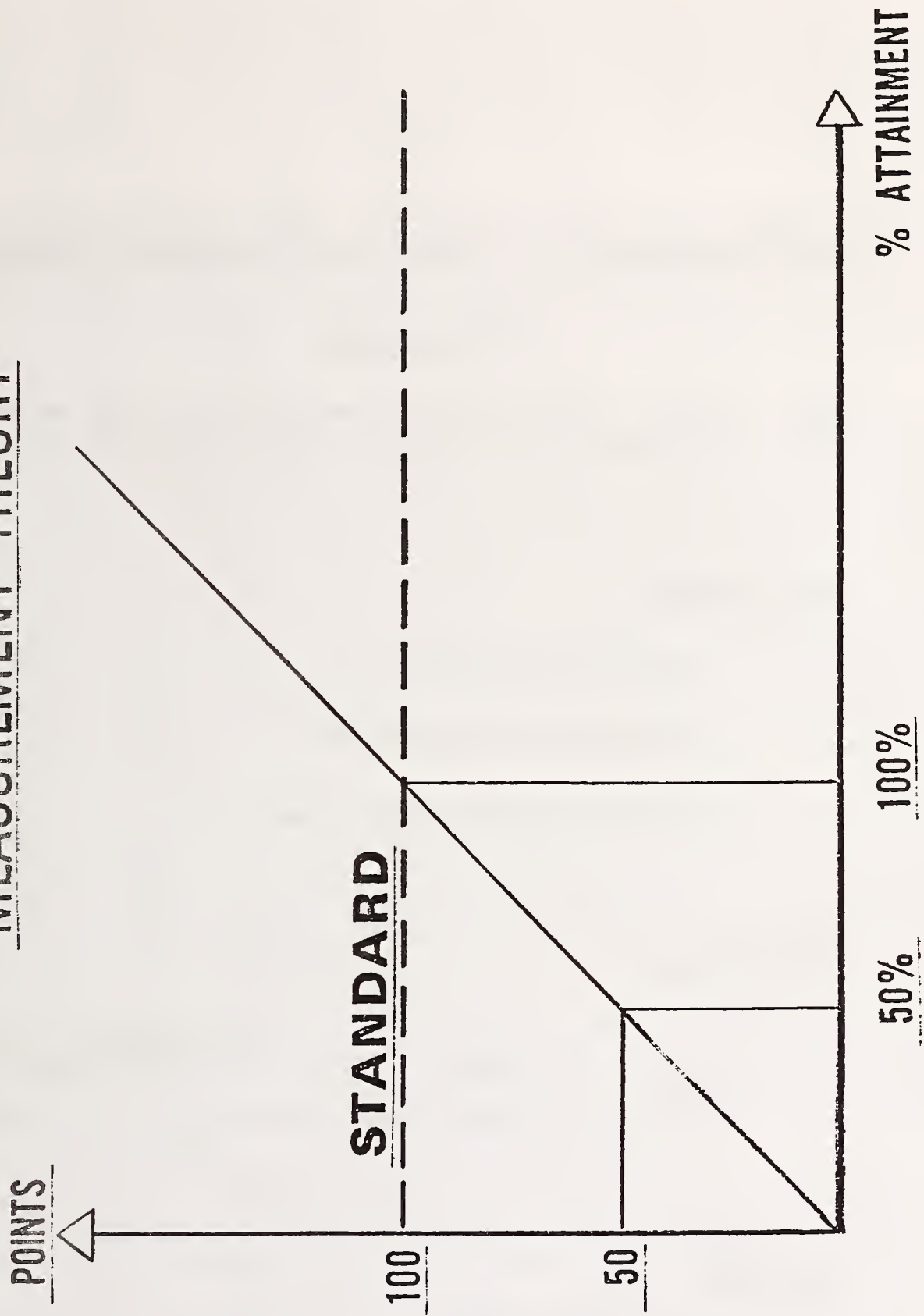


Figure 5

PERFORMANCE STANDARD MEASUREMENT

Example

STD: NINETY-FIVE PERCENT OF PROVIDER CERTIFICATIONS MUST
HAVE BEEN ISSUED CONSISTENT WITH THE STATE PLAN

MEASUREMENT:

1. CHECK STATE POLICY
2. DRAW SAMPLE OF PROVIDERS
3. REVIEW SAMPLE FOR COMPLIANCE

POINT AWARD:

$$\text{POINTS} = \frac{100 \times \frac{\text{NR CONSISTENT WITH PLAN}}{\text{NR IN SAMPLE}}}{.95}$$

EXAMPLE:

Assume - Sample of 100
80 are consistent with plan

$$\text{Points} = \frac{100 \times \frac{80}{100}}{.95} = 84$$

Assuming that there were a sample of 100 and 80 of the sample cases were consistent with the plan, then you would get 84 points for that standard. We have a continuum. It is not a nothing or all situation.

Now that the standards and measurement criteria have been developed, we needed to pull this together and come up with a unified certification or assessment approach, which we don't feel exists today. To do this, we began by using a term which has become popular, I have noticed, in the last few months: we defined some building blocks, four of them to be exact. These are shown in Figure 7.

The first building block is data elements. Data elements do not fall under the performance standards, but we feel that there is some minimum set of data elements which must be defined, not necessarily those that are defined today. That is a task we have begun to work on, looking through PRG-31, and making some recommendations to HCFA on some data elements that should be removed and some that should possibly be added.

The second building block is the performance standards. A third building block is the functional standards which were developed. A fourth building block, which we will address, to some degree, is a Federal report set, possibly the MMDS. We want to separate the current MARS management reporting that the States need to manage their program from some minimum amount of data that the Federal government needs to support the program at a national level.

HCFA should develop a single uniform reporting structure that they need, that can be provided either on hard copy or on tape. The Federal report set is what would be used for certification, not the current MARS subsystem. The States should decide what management reports they need to manage their own program; and if they decide wrong, let that fall out in the performance standard measurement.

So, once we have the building blocks, the next thing that is needed, as is shown in Figure 8, is to put these together and come up with a unified approach. By taking our individual building blocks and applying the measurement criteria to each of them and then combining them in some flexible manner we end up with a total overall score which determines whether you are certified or have passed the assessment.

Inherent in this scoring methodology is a continuum of score, so that we could apply incremental funding. If you achieve a certain minimum, you pass, but if you only attain the performance standards not quite to the full extent, you don't lose all of your money. You only lose the amount of FFP, dependent upon to what degree you fail to attain those standards.

Figure 9 is an example to show how that would work. There are all sorts of combinations that you can use, but the example that I have chosen is to look at the total system with incremental funding involved.

I also chose all four of the building blocks: the data elements, the Federal report set, performance standards, and the functional standards. HCFA could decide that for certification all that is needed are the data elements, the Federal report set, and the functional standards. The rationale for omitting the performance standards being that you can't have developed performance standards or performance at an initial certification. Then for periodic assessments, perhaps data elements would be omitted. Thus, the approach, we feel, is very flexible.



SYSTEMS
TECHNICAL ADVISORY
GROUP

CERTIFICATION/ASSESSMENT BUILDING BLOCKS

DATA ELEMENTS

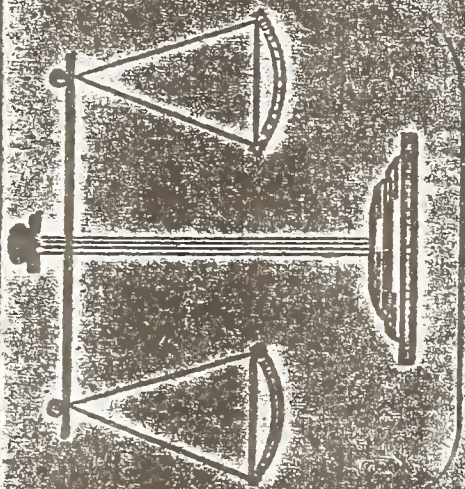
01 PROVIDER NAME

05 LAST NAME

05 FIRST NAME

05 MIDDLE INITIAL

PERFORMANCE STANDARDS



FUNCTIONAL STANDARDS



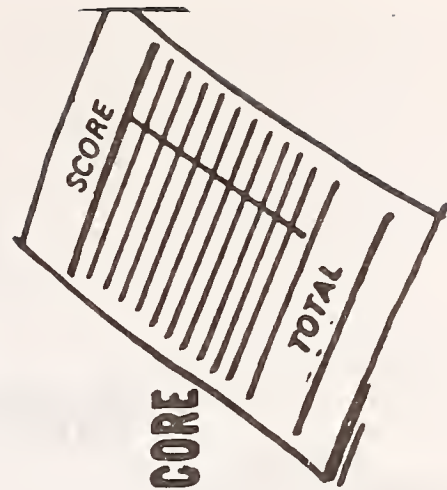
Figure 7

CERTIFICATION/ASSESSMENT GENERALIZED APPROACH

COMBINE



SCORE



MEASUREMENT



BUILDING
BLOCKS

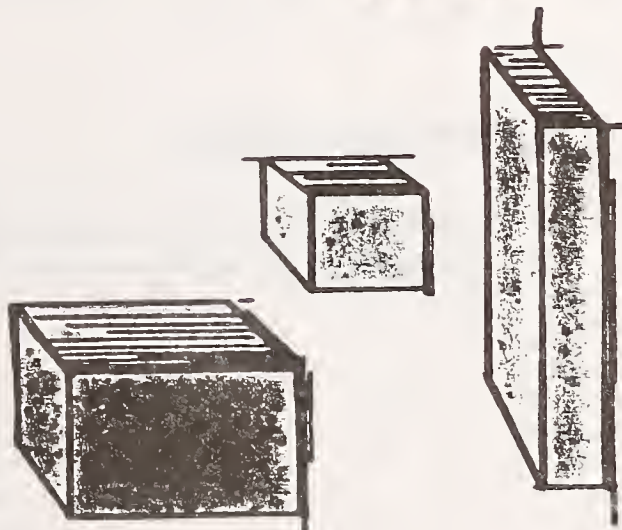


Figure 8

**SYSTEMS
TECHNICAL ADVISORY
GROUP**

FUNDING ASSESSMENT INCREMENTAL FOR TOTAL SYSTEM

Example

BUILDING BLOCKS:

**DATA ELEMENTS
FEDERAL REPORT SET
PERFORMANCE STANDARDS
FUNCTIONAL STANDARDS**

CRITERIA:

APPROVAL GRANTED IF

- **ALL DATA ELEMENTS PRESENT**
- **ALL FEDERAL REPORT PRODUCED**
- **MINIMUM TOTAL SCORE OF _____ POINTS
ON PERFORMANCE STDS**
- **MINIMUM TOTAL SCORE OF _____ %
ON FUNCTIONAL STDS**

MATCH CALCULATION:

**WEIGHTED PERCENT OF 50% BY WHICH PERFORMANCE AND
FUNCTIONAL STDS ARE MET ADDED TO THE BASE OF 50%.**

Following through this example, the first criteria that we have assigned is that all the data elements must be present. That is a straight pass/fail. Second is that the Federal reports, not the MARS reports, are all present or can be produced. Third is some minimum score of a total number of points on the performance standards. Finally, a minimum total score of a certain percent on the functional standards must be attained. Remember, the functional standards can't be measured. They are either yes or no, but you add them all up, and you get a certain percentage of them yes.

In order to determine the match calculation, if you are in the situation that we are in today, once you pass the above criteria you will get 75%. Otherwise, you get 50%.

If, in fact, you are in the situation where you can do incremental funding, then the scores on the performance standards would be used. A weighted calculation depending on how well you achieved the total cutoff score is the amount of funding that you would receive.

We feel this is a flexible package. We feel that it's a workable one, and one that HCFA can utilize. They can put it in initially with very high cutoff scores. Then, as experience is gained, these can slowly be lowered, either at the minimum total score or each of the levels on the performance standards.

What we have tried to stay away from concerning the development of the standards themselves is getting into arguments over each specific performance standard cutoff. We have tried to stay out of those standards and to come up with an approach that can be refined and implemented slowly by HCFA, so that we can get a very good consistent application which is fair to all of the States.

MR. STANSBERRY: My reason for being here is to bring you up to date on what has been done in reviewing or testing the package that has evolved from HCFA. On Monday, March 17, 1980, we did begin two and a half days of full review of the Michigan MMIS system according to the performance standards as drafted by HCFA.

This test or review was conducted by five people, three people out of the regional office in Chicago, John Walker out of Baltimore, and myself representing the NTAG group.

The jury is still out insofar as the regional office and central office comments on that test, but as an NTAG representative and a State person, I feel like the test went very well.

The Michigan people, Paul Allen and Bruce Kozlowski, approached this test in a very constructive fashion, accepting all comments of potential criticism or improvements to their program, as all of us should.

They did cooperate in full and pulled the sampling for us, which we ran through the various segments of the performance standards as developed by HCFA. We went through four major areas of review as designed in the performance standards. We did not go through the MARS and SURS aspect. As Allen Miller indicated, those are still controversial. There is still some discussions as to how to use those, therefore, we felt like we would not get into that.

But you could see from the review of the Michigan system, that they did use the MARS and SURS reports to better their administration and to give them the information they needed to administer the program.

So, I feel that the test went very well. We did get a very good review of a computerized system. It was a very good experience for myself, coming from a smaller State. I could see the benefits of having a smaller operation, as opposed to an operation which is seven times larger than ours, therefore, giving us the benefit of providing on-line documentation and results, whereas, with a larger facility we are not able to do that as readily.

There are some comments, I think, from the regional and central offices towards this test. We will have another test in Idaho next week. There will probably be another two or three before the end of the year.

I think HCFA learned from this test and is making some comments and adjustments in their package. That package has been provided to you. Please review it, and review the package that is sent to you from the States or from the NTAG group.

There are some variations. The variations from that package to the NTAG presentation is in exactly what Allen Miller has indicated here, the scoring methodology. This refers back to the original presentation of the NTAG group when we presented the performance standards to HCFA.

In the preamble, we asked very emphatically that, with a scoring methodology, that the States not be ranked in the bell system. We already see some indications that that certainly will be done. We still feel very strongly that we don't want to be ranked. There are 53 different programs. They have

their own uniqueness. This is an area in which we feel you don't want to be ranked. That is what we have received from communications from you. So, that is one area you may want to comment on.

So, if there are any other areas that you feel that the NTAG group can communicate to you or for you, Allen Miller is the new Chairperson, and you will need to communicate with him.

STATE DIRECTORS' REPORT

Glenn Johnson
Chairperson
State Medicaid Directors' Council
Harrisburg, Pennsylvania

MR. JOHNSON: As you know, we had the opportunity to deliberate and exchange problems and ideas for about a day and a half. It seemed about every other subject discussed related to long term care. It really was the predominant, prevailing issue with the State Directors in our session.

Before going into the highlights of the report, I will qualify my comments by saying that what is shared with you today is not the reasons for our recommendations, but the skeletal substance, pending final clearance of the report and circulation among the State agencies.

Our long term care concerns are in various areas. We want to assist the new Department of Health and Human Services and mutually develop short and long range goals, a strategy, plans, and policies for this sensitive service. Specifically, we recommend that there be State representation on the HCFA Long Term Care Task Force, which we heard about during the workshop and learned what activities they were undertaking.

In addition, we feel that there should be a State representative, possibly at the Administrator level of a Single State agency, or the Deputy level, on the Long Term Care Advisory Body of the Under Secretary of the Department of Health and Human Services.

In addition, we suggest that another IAG, or a Technical Advisory Group, be established on Long Term Care. This would be comprised of State and HCFA representatives, similar to the other IAGS.

Also, on long term care, the group supports the adoption of the Community Care Act (HR-6154), or something like it, when it finally emerges and especially with the option for States to provide noninstitutional services and personal care services, to avoid the need for institutionalization of Title XIX patients.

As a related or companion recommendation, the group also supports modifying Title XX rules, and/or law if necessary, to encourage greater use of community based services at possibly 75% FFP or a higher FFP level, to avoid the need for institutionalizing Medicaid patients and to provide alternatives to institutional care.

Fourthly, under long term care, there is concern about the SNF evidentiary hearing provisions of the regulations and how they impact on payments and financial participation. We recommend that consideration be given to continuing FFP during the period that a provider appeals an adverse action by a State agency. If there is a disallowance of FFP for long term care services, it should start prospectively after the decision on a hearing or appeal.

So, there was a considerable time and discussion centering on long term care. There were various other aspects that will not surface here today. Long term care is really emerging as the predominant issue in Medicaid administration.

Another area is old hat, EPSDT. The States wish to express their deep concern about their ability to meet the detailed process requirements of the final Federal regulations. They are also disturbed by the potential fiscal liabilities and being held responsible for circumstances which possibly are beyond control of the State agency, such as the availability of certain types of providers -- dentists and others -- that are scarce if not available in some areas.

There is also concern that the lead time of only four months after final adoption of the EPSDI regulation is far too short for the States to be expected to be in compliance. When regulations were out as proposed, and until the States know what the final detailed requirements are, they do not proceed to implement a regulation. So, despite advance notice, and until the final requirements are published, four months lead time allowed will really create problems.

These are the substantive issues in relation to the Medicaid program. There were other issues discussed. Our organization's bylaws were amended by the group. We just became used to the name, Council of State Medicaid Directors, but probably around June 1, the group's name will be changed to the State Medicaid Directors Association. It will also become an affiliate organization of APWA, through which recommendations and major policy items will be cleared.

The Committees that we have may possibly be slightly changed, very slightly, but Paul Allen, the new Chairman, and the other leadership will be clarifying them for you. However, the group did decide yesterday, as a result of our meeting with Millie Iyssowski and other key HCFA staff, that there should be a new Long Term Care Committee, as far as the Council is concerned. Jack Knowlton of New York, will be the chairman of this Committee. So at the moment, there are seven committees, but it's possible that they will be slightly realigned.

Also, the group elected the new officers for the upcoming year. Paul Allen, the Chairman, is from Michigan. Tom Russo of New Jersey is the Secretary. Charles Pierce from Georgia is the Vice-Chairman, and Sharon Marcum from Arkansas will be the Treasurer.

We still feel that there has been continued improvement in Federal/State communications and the relationship. We think it is evidenced by the fact that we now have the State Medicaid Advisory Group, which is convened quarterly. We met yesterday in conjunction with HCFA staff. It is a very positive, organized medium for exchange of ideas.

Also, we now have approximately ten Technical Advisory Groups, plus various other Subcommittees and Committees. In addition, there have been other interfaces during the year between special offices -- Program Integrity and Systems.

We see increased activity, interchange, and opening of ongoing channels for communication. We think this is healthy. I hope we will continue to foster and further this.

I wish to thank, on behalf of the Council, the people who really do the work: Tom Smith of Georgia, who is the current Treasurer; Ernie Rumpf of Wyoming, who was our Treasurer. We have our present Committee Chairpersons who have worked hard this year. These are the people who really do the work in the Council; it's not just coming here for the Annual Meeting. We did want you to know that we give high credit to these chairpersons; they are the major links with most of the HCFA staff on the program.

We also wish to express our thanks to HCFA staff, Mary Kenesson, Ed Palder, and the others for the logistics in making this conference possible. We know it's more than a State meeting, but I think we want you to know that we're grateful for this opportunity to meet together in this type of forum.

INFORMATION SYSTEMS IN THE 80's:
DIAGNOSIS AND PROCEDURE CODING SYSTEMS

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Executive Assistant
Department of Social Services
Columbia, South Carolina

William Cresswell
Branch Chief
Division of Hospital Experimentation
Office of Demonstrations and Evaluations
Office of Research, Demonstrations
and Statistics
HCFA
Baltimore, Maryland

Alexandra (Sandy) W. Cook
Government Affairs Representative
E.D.S. Corporation
Washington, D.C.

MS. McCULLOUGH: I want to tell you a little bit about the integration project that we have underway in South Carolina.

For you to understand the significance of the project and something of the relationships that exist between Medicare, Medicaid, and Blue Cross-Blue Shield, I need to give you a little background.

In 1973, Blue Cross-Blue Shield, which is the Title XVIII carrier, became the fiscal agent for processing all physicians' claims under Medicaid. At that point we started negotiating on a common claim form and the Medical Association in South Carolina took the primary lead role in helping us to accomplish it. So, with Blue Cross-Blue Shield becoming the fiscal agent for Medicaid, we also implemented the common claim form. It's the same basic claim form that's been discussed previously, the AMA claim form with just a few variations to include some of the data needed by Medicaid.

The continued relationship with Blue Cross-Blue Shield has fostered a lot of personal relationships which have meant that we have been able to discuss a lot of problems through the years.

In August of 1979, the Medicaid agency began implementing the MMIS system, so the contract with Blue Cross-Blue Shield was terminated. But we continued to have that same core of people working together, talking about mutual concerns.

When we started planning for MMIS, we, of course, were thinking about going to the CPT-4 program and did not know for sure whether this would be a good plan or not. As we were still talking about it, our Medical Association approached us about implementing the CPT-4 program and at the same time, talked with Medicare and Blue Cross-Blue Shield. We agreed that, as we implemented the MMIS, we would move to the new coding system.

Blue Cross-Blue Shield and Medicare decided that they would talk about it, but they did not fully decide to move in this direction until some months later. Needless to say, the conversion to the CPT-4 code was a very time consuming process. We had three full time nurses, with consultations from two M.D.'s, who worked many hours to come up with this conversion.

We thought that, while there were a lot of other important tasks, there was none more important than the conversion because we knew there could be just utter chaos if, for any reason, we did not do this correctly. We realized that it could cause us to overpay, underpay, could even cause a compliance issue if we exceeded the Medicare payment levels.

After completing the conversion, we instituted, within the agency, our own QC system. We ran this QC for some time before we actually started processing claims and it is being continued regularly.

Several States have contacted us about our conversion tape and we've had a good bit of dialogue about it. One good thing about the conversion is that after we completed it, Blue Cross-Blue Shield decided they would go to the CPT-4 code, and so, they developed a conversion tape also. So we've been able to bounce these two tapes against one another and this has been quite a positive thing for both of us because it assures its accuracy.

Upon being selected as the participation State in this project, Blue Cross-Blue Shield and the Medicaid agency appointed a project team. We actually had four individuals representing each of us and they carried the major responsibility for the project. Each team has numbers of backup staff and technical people that can help them wherever necessary and they bring decisions to me that I can handle at my level or the ones that I have to take to the Commission.

Printing of the materials, the system changes, and the small number of staff will be funded through this project.

In April and the early part of May, we worked jointly on a physicians' provider manual. We call this Volume 1. This manual will give all the information relative to each program coverage in one volume. It looks like it's going to be a very workable manual now, each filing clerk had three separate manuals they had to refer to from time to time, they will be able to turn to this one manual to find the program coverage.

We continue to have responsibility for providing the information for the manual. We are going to be -- in the Medicaid agency I speak of -- the determiners of what goes into that manual. We are not relinquishing any of our programs responsibility. As I mentioned, these manuals have now been printed. Likewise, Blue Cross-Blue Shield is printing and distributing all of the forms that will be used.

Volume 2 of this manual is a reproduction of the CPI-4 programs, with a cross reference to Volume 1 indicating coverage or non-coverage for each of the programs. We think this will be extremely beneficial to the filing clerks as they determine coverage.

Physicians currently using what we call the silver book, which is the CPI-4 book, which is published by the AMA, is a listing of the codes, but it does not in any way reference whether these are codes that are covered by certain programs.

Workshops have been scheduled for the last three weeks in June in preparation for implementation July, 1980. They will be held by Blue Cross-Blue Shield staff and the provider relations staff of the Medicaid agency.

We plan to further coordinate the work of the provider representatives of each program in order to avoid duplication of visits.

We know that we will always have particular or certain questions that we have to answer for ourselves; for example, payment (if it is a question around that area), it would come directly to us. But we already can plan to have these representatives coordinate their work and we feel that this is going to cut out some additional costs for us.

We will continue the policy of joint communications and we know, too, that the manual that we've just completed, while we think it's pretty good, will have to be constantly updated.

HCFA has established a technical advisory group which will develop recommendations concerning appropriate terminology and coding for the non-physician services. These will be forwarded to our project teams for evaluation and analyzation so that our program services will not be altered and

costs will not escalate. We are not duty bound to implement programs if, for any good reason, we feel they would be detrimental in any way.

Also, our project teams can forward to the national IAG group any recommendations for additional codes to the system. If they take these under advisement, they will later let us know whether or not they can be included in the program.

The next few months will be very busy ones for us, as we produce about six or seven additional manuals and as we develop other common claim forms for such services as dental, DME, and ambulance.

The primary purposes of both of our project teams has been to delineate the areas that have commonality, to identify those where the programs are uncommon and where there are statutory requirements that preclude our ability to affect change. The attitude of the State Medicaid agency is one of wanting to participate in this demonstration. We feel that we have an opportunity for some input, an opportunity to influence, to some extent, the future direction in the area of bringing XVIII and XIX together in a way that will promote improved participation from the provider community, reduce duplication of costs and, most of all, the program will become more responsive to the needs of the eligibles.

We feel the project is one that will demonstrate a type of relationship where each program must be flexible to some extent. It's important for us to maintain a certain amount of identity of each program and, certainly, it's very important that we are not always the one relinquishing all of what we think we should hold to, but rather require the same of Medicare.

The other important aspect of this will be items that come to our attention that we had not thought of when we first started talking about the integration project. One example is the need to develop codes for outpatient surgery. We have certain groups that have already come to us with proposals to do, on an outpatient basis, cataract extractions. By using the CPI-4 code, plus some modifiers, we could save a minimum of \$2,000 on each one of these cataract extractions by having this done on an outpatient basis. We will be asking Baltimore to help the Medicare carrier go along with us on this aspect. This is just one of the things that we have talked about within the last ten days.

Another area of concern is comprehensive health clinics. Not the rural health clinics, but the comprehensive ones which bill directly to Baltimore on a fixed fee charge.

The Medicaid agency will be moving to the CPI-4 coding for these clinics in July. Here again, we are going to ask Baltimore to consider doing the same, because we think it will be cost effective, and here again, we will be able to learn a great deal more about the kinds of services that are being delivered there.

This is just a bird's eye view of where we are and, beginning in July and the subsequent months, we'll know a lot more about the project. But we are excited about it.

MR. CRESSWELL: I appreciate this opportunity to provide some information to you and solicit your involvement and input on some of the initiatives that the Office of Research, Demonstrations and Statistics, within HCFA, has underway. We hope this will be the first of many opportunities for dialogue and exchange of ideas and concepts between our office and your Medicaid agencies.

The initiatives encompass uniform reporting for institutional providers reimbursed under Medicare and Medicaid. Section 19 of Public Law 95-142 mandates development of uniform systems for cost utilization, capital assets, billing, and discharge data for providers reimbursed under Medicare and Medicaid. That's a range of systems, the first of which is the System for Hospital Uniform Reporting, now redesigned and renamed Annual Hospital Report, which I'll cover later in my presentation.

I was interested in hearing Blanche McCullough's statements, and encouraged with respect to the cooperative efforts within South Carolina. Progress is complicated by a need to maintain continuity in programs which are similar in some respects but quite different in others. But the goals: the improved cooperation of the providers, reduced costs, and greater responsiveness to the needs of the eligible population are worth pursuing.

When government financing of health care began, Medicare and Medicaid program operations were patterned after the systems used by health care insurers of the day. Existing approaches and tools were adopted for the public programs. Early in the development of the program, automation in health care information processing was nearly nonexistent. There was some automation of physician billing, but almost none on the hospital bill side.

During the period of growth and development which followed, programs were added, requirements were changed. Both public and private sectors refined their operations to meet their own growth needs and responsibilities. As the industry expanded, so did the data and information handling systems.

Those systems met the needs of the individual users. But overall, the systems we use to process information and pay claims are incompatible. This hampers communication, contributes to inefficiency and inflation, and makes it extremely difficult to aggregate and analyze data. For example, in an acute care hospital that has to meet the information needs of various third party payors and PSROs, it's not uncommon to see any of a number of different variations of inpatient bills; the Medicare bill, your Medicaid bill, Blue Cross bill. In addition, there may be a combination bill for commercial insurers, or individual bills for commercial insurers. In many cases, different procedure and diagnosis coding schemes and different designations for ancillary charge items are in use, and that's just part of it.

There are abstracts for hospital statistics and others in abstracts to satisfy PSROs. We pay for both of them. In some cases, Medicaid agencies also require the discharge information as part of the MMIS. All of these documents are abstracted from either billing records or medical records on the same patient. From HCFA's perspective, we pay at least 42% of this cost through Medicare and Medicaid. For some of those instruments, we pay the entire cost of extracting the information.

This inefficiency and, again, the incompatibility with respect to information across our programs, was recognized by Congress in passing Public Law 95-142.

To meet the requirements of the 1980s, we must build new systems that reduce redundancy and improve the timeliness, accuracy, and efficiency of the health care financing process. We want to collaborate with you, with our Medicare intermediaries and carriers, with the providers and the industry in general, to develop a process for simplifying and unifying our health financing information systems throughout the industry. Mr. Schaeffer's statements, earlier in the conference, clearly articulated HCFA's intention -- to work with our agents and all of you to renovate our approaches to the collection and use of information.

One focus of this will be the establishment of common grounds for communication through common coding, common definitions and identifiers in data sets, all designed to meet the needs of multiple users, including Medicare and Medicaid. In this area, we can realize immediate improvements in accuracy, timeliness, reduced costs, and a reduction in reporting requirements for providers.

In addition, technology is changing rapidly. We, in HCFA, are testing various models of linking and transmitting hospital billing and discharge information. One basic model integrates and automates data at the hospital. The provider can then transmit the data either to a central clearinghouse or directly to the third party payor. In the case of the clearinghouse model, the clearinghouse will reformat the data and forward it to third party payors, PSROs, State and local health planners, rate setting agencies, and others.

We are presently funding demonstrations in Missouri, Maine, South Carolina, Vermont, Minnesota, New York and, in addition, we have one on family practices with the Department of Community Medicine at Dartmouth.

In these demonstrations, there is active involvement by the Medicaid agencies. That involvement takes varying forms. The goal of the entities funded in these States linked billing and discharge data for each patient in a single transaction that meets the needs of all users. Users agree to work through a single organization to consolidate their needs. That means, in the case of some States -- New York, as an example -- all 17 of the PSROs have agreed on a common data set. The HSAs have also agreed to get their data from this data base.

Medicare and Medicaid have to come together, as in the case of New York and some other States, on a common billing format, be it tape or hard copy, and on common codes -- procedure, diagnosis and revenue coding -- within that format.

These demonstrations are expected to prove that the development of consistent definitions and coding schemes and the use of integrated automated systems provide advantages for all participants.

We are in the process of awarding an evaluation contract to look at all of the demonstrations that we've funded. The evaluation process will probably last about three years.

We anticipate that providers can expect more accurate reimbursement and more timely turnaround information. There's some debate on that, but our contention is that, if you can capture the information once in the institution, and move it out electronically, you have the basis for improved and more timely information flow.

Besides the cash flow issue in hospitals -- we're also looking at the privacy versus access problems. We've run into considerable and interesting conflicts within New York, as one example, on the privacy issue. When you develop a data base, which encompasses all patients in the State, and make it available to legitimate users, as well as make general aggregates of those data available to other users, you encounter political considerations that never occurred before.

If you are a Medicaid organization processing Medicaid data, you don't have a problem. If you're a Medicare organization processing Medicare data, you don't have a problem. When you put all that data together in one place, however, you have many problems. New York's approach to addressing the issue was to establish a review board which passes judgment on requests for information.

I want to talk for a moment about some of the tools for accomplishing our objectives, ICD-9CM and CPI-4.

ICD-9CM is a generally accepted diagnosis coding scheme for use in all settings for both reimbursement and research purposes. HCFA plans to go ahead with implementation, mandating the use of ICD-9CM for diagnosis coding in our program. It has been implemented across most of our programs. The PSRO program has adopted it for diagnosis coding purposes, and we plan to publish a notice in the Federal Register requiring the use of ICD-9CM diagnosis for Medicaid later this year.

CPI-4 is a procedure labeling system. HCFA programs have two major uses for procedure information: one, for determination of reimbursement and, two, for professional fees and the conduct of professional standards review.

Consultation between HCFA and the health care industry has led us to conclude that a uniform procedure labeling system could and should be developed, based on the physicians' Current Procedural Terminology, Fourth Edition, CPI-4.

The features of CPI-4 which suit it to be the standard procedure labeling system for all HCFA programs are one, it's already familiar and used by many physicians, and, two, it contains the most comprehensive listing of terminology describing medical procedures and practices.

CPI's coding structure, five core digits plus two digit modifier codes, is adaptable for procedure coding for ancillary services and for clinical activities in general.

There are many third party payment programs, including several State Medicaid agencies, which have used CPI-4 for their reimbursement needs.

The American Medical Association has the means to keep the contents of CPI-4 updated to reflect changes in medical technology. In this process, AMA considers recommendations for change from sources throughout the health care industry.

The costs of implementing a CPI-4 based system appear lower than the costs of adopting another widely used system, or developing a brand new system.

The AMA has indicated its willingness to come to an agreement with HCFA concerning copyright and other issues associated with the use of CPI-4.

This year, HCFA will review CPI-4 to see what modifications are needed to make it suitable for use in all settings, so that there can be a common approach to procedure labeling for the Medicare, Medicaid, and PSRO programs.

The South Carolina project, undertaken by the South Carolina Medicaid agency and the South Carolina Blue Shield, is an integral part of that process. The results of this effort and the plans for testing and evaluating the resulting prototype will be shared with you and all interested parties. The general schedule calls for the prototype including the modifications to be available sometime early next year. We then intend to field test the modifications so final decisions on the specifics of implementation will not be made until much later next year, according to the present schedule.

Our goal is to move in the direction of CPI-4. There are some methodological and technical hurdles that must be overcome. We will then review the results with the industry and begin the implementation.

We plan to continue working with you all; with the Public Health Service National Center for Health Statistics, AMA, and the American Hospital Association, as well as other representatives in the health care industry, in the development of CPI-4.

We intend to pursue a policy of moving towards use of a single procedure terminology system for use in reimbursement and ultimately across all settings.

We are confident that a CPI-4 based system can be used for reimbursement purposes without adding to inflationary pressures. HCFA intends to establish its use throughout Medicare and Medicaid and PSRO programs. We expect an active dialogue as this project develops. Once the decisions are finally made, ample notice will be given, through the Federal Register announcements and updated policy papers, to you in the Medicaid program as well as to Medicare.

The next issue I'd like to touch on is the development of uniform tape specifications for hospital submission of billing information to Medicare and Medicaid.

We, at HCFA, are working to develop a single format of automated billing specifications for all types of providers. In the future, anyone submitting a nonpaper claim for Medicare or Medicaid reimbursement will be submitting the claim in that format.

The specifications include an administrative portion, which deals with the records to be kept by the provider and the auditing procedures to ensure their completeness and accuracy, and a technical portion which instructs data processing personnel in its use.

To date, HCFA has conferred with the Medicare systems technical advisory group -- TAG -- to develop the specifications, worked with the insurance industry to make the specifications adaptable to as many settings as possible, and developed a document which we think will meet the needs of the industry.

Medicaid agencies, to date, have provided relatively little in the way of comment and recommendations in the development of these specifications. For this reason, a meeting of the Medicaid systems TAG has been scheduled for June 10th. We encourage all of you to make your recommendations and comments through that TAG to HCFA. You have a great deal of experience in this, and we look forward to your recommendations through the TAG.

Once the specifications have been finalized and put into manual instructions, Medicaid State agencies will be required to mandate the specific file and record formats for all automated bills except those received via telecommunication. The date of release of advance copies of the manual instructions is scheduled for later this year.

I'd like to talk a little about uniform billing, specifically, uniform institutional billing. Public Law 95-142, Section 19, requires a uniform system for reporting bill data by health care facilities. Long before Section 19 of Public Law 95-142 passed, uniform bills of various types were in place around the country. I think the granddaddy of all of them was the A92-R in South Carolina. It has been there a long time and has been working effectively.

The current uniform bill, version UB-16, is currently being field tested in five States -- Arizona, Connecticut, Florida, Nevada and Ohio. In addition, the UBF-1 -- a very different kind of uniform bill, developed in New York State for reporting data to the State Office of Health Systems Management and to the uniform data base I referenced before -- has also been implemented across the State.

Both types of uniform bills are being tested. A contractor is evaluating the impact of these uniform bills on hospitals and third party payors in two phases. Phase 1 is collecting data from hospitals and third party payors in the test States; from hospitals across the country and from other interested parties, via mail survey, site visits, and conversations. Phase 2 includes an analysis of the data, examination of different revenue coding systems, comparison of the two uniform bill forms, case studies of implementation strategies, and assessment of hospital and payor opinions of HCFA's uniform billing policy.

The final report on uniform bill demonstration projects should report industry expectations, document problems and advantages of specific forms and codes, and recommend a decision to HCFA concerning the mandate of specific uniform bills.

HCFA is committed to bringing this process to a conclusion, in terms of recommendations, by the end of this year and tie it together with the reporting of tape information to intermediaries and State agencies. We support State movement towards uniform billing and activities leading in that direction.

It's my understanding that a number of you have a great deal of interest in moving towards uniform billing. Next year we expect to begin implementation in a coordinated fashion with the tape specs. The specific timing of plans and mandates has not been determined at this point.

We have a number of other uniform reporting activities which are underway, which will likely be of interest to you.

The Annual Hospital Report, formally called "The System for Hospital Uniform Reporting", is a uniform system for reporting of costs, capital assets, and utilization information for cost based reimbursement. Designed specifically for Medicare reimbursement, it is equally applicable for any cost based Medicaid reimbursement of hospitals.

Using the Annual Hospital Report instrument for example, an assessment can be made as to whether some kind of prospective reimbursement is appropriate or is not appropriate within the State. If a decision is made to go in that direction, the reporting system would not have to be changed.

The original system was somewhat cumbersome, 600 pages long. It overwhelmed many people, including me. We've since cut the system drastically. In terms of bulk, it's half the size that it was. We've taken into account most of the burden concerns of the industry, and the present system, which was announced in the Federal Register as a Notice of Proposed Rulemaking on March 19th, only adds four forms for uniform reporting over and above the Medicare reimbursement piece.

We plan to publish a final rule by year end and begin implementation for fiscal years beginning July 1981.

We encourage use of this system by State Medicaid agencies and movement toward the common audit for Medicare and Medicaid which this will facilitate.

Our current plans call for full automation of this system, concurrent with the implementation. We will encourage and support the placement of an automated desk review process, so that the information can be edited on some kind of time sharing basis at the intermediary, be used for final settlement, for audit for Medicare, and for common audit for Medicare and Medicaid.

Long term care is an area we're just about to get into in terms of uniform reporting of costs, utilization, and capital assets. We particularly require your active involvement and support. You have a lion's share of the activity in long term care.

We don't have a system in our back pockets. We intend to start from scratch, build an industry work group to work along with us, and have a contractor to go out and survey existing approaches to reporting of long term care cost information. We want to build a system that meets HCFA's reimbursement needs and the needs for comparable information across long term care facilities, the needs of the States, and is acceptable to the industry. We solicit your active support.

With respect to HMO uniform reporting, we're in a very early stage. We recently awarded a grant to the Group Health Association of America to survey the various reporting systems that are in place across HMOs. At present, there is a mosaic of requirements from Medicare, Medicaid, the Office of Health Maintenance Organizations in the Public Health Service, and the Federal Employee Benefit Program. All of the requirements associated with these programs change, and there is not much coordination.

Our goal is to complete the survey. The grantee will then recommend a prototype family of systems to encompass membership, enrollment, utilization, financial data, and reimbursement.

By building within the industry, we hope to be able to develop a system that will meet at least the needs of the HMOs, HCFA, PHS, a broad cross section of State Insurance Commissioners, as well as private industry.

In summary -- I've just discussed a wide range of initiatives which all fit within the overall framework articulated by Leonard Schaeffer in his presentation on HCFA's perspective of health information in the 1980s. That paper will include all of the information initiatives which we have underway -- a major step in announcing that HCFA intends to improve its dialogue with the industry as we move along to develop our data systems.

This improved dialogue will mean more realistic decisions that are sensitive to needs of both the State and Federal levels. Once we make our decisions, HCFA funding will only support those decisions. The purpose of the dialogue is to make those decisions as realistic as possible. I encourage your support and assistance to eliminate the redundance, improve the comparability of information across our programs, reduce the burden on providers, and improve service to our eligible populations.

MRS. COOK: I appreciate the opportunity for industry to respond.

I am not a technician, but I have a few observations that I would like to share with you, based on experience in the field with people who are or have been adjusting to new policies being promulgated.

These observations are: one, we are working in a highly decentralized environment; two, investments are and already have been made in changes; and three, providers are having difficulty in realizing and understanding what benefits are to be derived from changes.

The movement toward national uniformity may be somewhat difficult to achieve, not because people do not want to be cooperative, but because changes are occurring in an industry that has been extremely localized, decentralized, and personal, and oriented to the local community for such a long time.

An analogy might be that when the automobile was invented, if each town had taken upon itself to build its own brand or type of automobile, compatible with the requirement for the roads in that area, we would have ended up with a lot of different looking cars. Instead, what we have are a few manufacturers -- Ford, whatever else.

Too, the movement toward uniformity is occurring at a time when the environment is already in a state of change. Even as we sit here, changes are being made. As States, providers, and contractors have done so, the changes have not all been made in the same direction, and this is one factor why movement toward uniformity may be somewhat difficult.

Providers, in particular, do not see what is in it for them. They understand the concept, the need for research purposes, reimbursement purposes, and epidemiological research. But if a provider has just invested \$200,000 in a new system and has yet to make further changes, the return, on a short term basis, is not too clear.

With what is going on, there are some things that we might look toward.

It would seem imperative for HCFA to understand local needs, and to allow realistic time frames, to allow sufficient time to comply or respond to new requirements. This would include allowing flexibility and tolerating some inconsistencies in data reporting formats in the transitional period, while everyone is getting their act together.

This would call for flexibility in policy, while other technological advances are taking place. Also, allowing some flexibility to meet particular needs in geographical areas would be appropriate.

I think that the bottom line is designing a transition period that recognizes these needs.

Questions?

QUESTION: This is a question to both Bill and Sandy.

Regarding what Sandy just said, Bill, have you done a catalogue of the various types of forms that are used in different States? Do you have a true

understanding of what all of the local differences and variations are; and are you certain that the new uniform forms that you are designing are going to accommodate all those differences?

MR. CRESSWELL: With respect to the uniform bill, it's been around for about ten years. The current design of that bill encompasses all of the institutional billing needs of anybody who reimburses hospitals or long term care facilities. The AHA has collected a cross section of the various billing forms that are in place, and assembled a uniform billing advisory group which includes all of the third party payors and the hospital industry. That's our understanding at this point.

QUESTION: Do you know what State requirements would have to be eliminated under the uniform bills that you're talking about, State by State?

MR. CRESSWELL: We do not know what State requirements would have to be eliminated.

COMMENT: I would suggest that there be some mechanism where you find that out because otherwise you implement a uniform bill, in Medicare you'll do it in a few States, and then you'll run into a lot of problems in the remaining ones.

MR. CRESSWELL: Let me point out what we've done in our demonstrations. We've come up with a common bill and discharge data set. Each State has a different total data set. The common nucleus is the UB-16 data set and the uniform hospital discharge data set.

The synergism that's taken place in these States has resulted in all third party payors either agreeing on that bill data set or that data set with a couple of small additions. It has resulted in all of the users of discharge data agreeing on a common increment to the uniform hospital discharge data set, so that the total data collected from institutions would vary across our demonstration States, but there would be a common nucleus for billing and discharge.

So, they are sensitive to varying needs across States.

QUESTION: I'd like to ask Blanche McCullough to describe how she is handling the diagnosis coding in her system? Do you do the coding? Do you furnish the codes? How's that done with your providers?

MS. McCULLOUGH: As I indicated earlier, for the CPI-4 code, we have printed Volume 2, and the nice thing about it is we have not changed any of the codes. But under each code is an indication where they can refer to in the narrative part of the manual to discern whether or not it is a covered service under whichever program they are trying to bill. Was that your question?

COMMENT: No. I'm asking about diagnosis coding, not procedure coding.

MS. McCULLOUGH: Oh, I see. We all use ICD-9.

QUESTION: Who codes?

MS. McCULLOUGH: The filing clerk in the doctor's office.

QUESTION: Have you furnished them with a coding manual, or have you asked them to get the ICD-9 CM, or how do you handle that?

MS. McCULLOUGH: This has been in place for a number of months in South Carolina, since this part of it is not new to them. We've used this code for some time, and the new part of it was going to the CPT-4, which we began in August.

COMMENT: I'm not sure. ICD-9 just came out, you know. It was just published here a year or so ago.

MS. McCULLOUGH: Right.

QUESTION: What I'm trying to get at is, how are you furnishing the codes, and have you asked them to buy the manual, have you made a synopsis of it? How are you handling the coding for diagnosis?

MS. McCULLOUGH: They have the codes, we have not supplied them.

QUESTION: So, it's up to them to buy the book or come by the coding information by whatever manner possible?

MS. McCULLOUGH: Yes. This has not been a problem for us.

QUESTION: You're lucky.

I'd like to address this to Bill. It's something that we've mentioned every time we've met with HCFA on the common claim forms for hospitals or for physicians.

We have a statutory requirement in Oklahoma that is not accommodated on any of the common claim forms. Will there be a provision for the States to modify the claim forms to accommodate additional State requirements?

MR. CRESSWELL: I think that we'll have to take those State requirements into consideration. I don't have a final decision for you. I can tell you that, with respect to our demonstrations, we have accommodated variations across the States, around a common nucleus. I assume you've made comments or you've notified HCFA with respect to your concerns and what the changes ought to be. Depending on what happens to the bill as a result of the field study, there may be some additional space made available.

And once you have the optional space, assuming it's not used for another program, that might provide one alternative. But I don't have an answer for you.

QUESTION: We've got the same problem in Kansas. We're looking at a common claim form that doesn't meet our total needs, and yet I'm hearing that you have not really even considered the claims as they are from the States, that you have looked at your demonstration areas and have assumed that that takes care of all the States.

I'd urge you to look at the States. For example, on the claim form there's no place where it can be indicated if EPSDT followup treatment is being claimed. That's very important to us in Kansas. And that, I'm sure, is important to a lot of States since that's an issue we're all dealing with.

Have you considered these kind of things?

MR. CRESSWELL: Our demonstrations, the ones to integrate data or the ones to field test the uniform bill, encompass ten States. Granted, that's not all the States. Up until this point, we have not encountered any problems that would not be accommodated on the bill.

However, please make those things known to us -- the systems IAG is the logical mechanism to do that -- before we make final decisions, because clearly it is not a uniform bill across our programs if it doesn't meet some specific State needs that have to be met.

QUESTION: Can you tell me if there would be any objection by HCFA, with regard to any uniform claims form, if we restructured the heading of any claim form so that it could be used with an imprinter?

MR. CRESSWELL: You don't have a uniform bill if we allow variations across all of the States. We would like to move towards a uniform set of data across Medicare and Medicaid.

I'm going to be a little evasive. To the extent that the tape format, which compliments the bill, is used, it has the capacity to accept additional elements and variations. The bill becomes a manifestation of what's included in the tape specifications, as opposed to an end in itself.

We haven't made a final decision with respect to what we're going to do with UBF-1 in New York, for example, which is a different bill from the UB-16.

All I can say is the UB-16, to this point, has a lot of active support across the industry and in many States. To the extent that you have problems with it, please make your concerns known to us.

QUESTION: I'd like to ask one question about use of the ICD-9CM. Are you going to require the full five digits and, if so, have you consulted with any of the organized medical groups to see how acceptable this will be?

MR. CRESSWELL: Our requirement for ICD-9 CM is to require the five digits. There has been extensive consultation with various groups. There is an advisory group composed of the American Medical Records Association, the AMA, APA, and BCA, among others, and there is a consensus on the use of this coding system.

COMMENT: I'm talking about practicing physicians and you've only mentioned one group, and they may have been outvoted.

The other thing I want to discuss while your attention is focused on it, every claim against the State of Oklahoma, not just Medicaid claims, requires a notarized noncollusion affidavit. Every time we've mentioned this to the Federal representatives, the response has been, why don't you get it repealed. My answer to that has been, anybody who is in favor of collusion, come down and see if they can get it repealed. And there is not enough room on any of the proposed claims for the statutory requirements of our State, unless you alter the claim extensively.

MR. CRESSWELL: Well, how is it done now, is it a supplementary form?

COMMENT: No. All our claim forms are so devised that they are on the claim form, Medicaid, Medicare, and the rest of them.

MR. CRESSWELL: I don't have a specific answer for you on that one, I just don't know.

MEDICAID BUDGETING

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MS. PERKINS: I just have a few remarks to make. I think you need to know that we've been working on some revised budget instructions that we'll be sending out through the IAGs system for you to look at and review.

The purpose of putting this on the agenda today is an alert that the Federal government needs to do a better job in explaining and justifying the national Medicaid budget.

As you all know, we've been collecting from you the Medicaid annual estimates from each State from the early 1970s, in the form of the OA-25. That form and the required contents have not changed substantially within the past four or five years.

Our main problem has been our difficulty in aggregating the input that we get to the national budget, and to explain that to the reviewing bodies on up the line, the Office of the Secretary, OMB, and the Congress.

During the past several years, those State estimates have been, in the main, used to report to the Congress the status of current budget year requirements. This has been a quarterly status report. Also, these State estimates have been used to test against our national assumptions for budget requirements. However, it hasn't been the main basis, in the past two years, for our budget estimate to the Congress.

Last year, it became apparent that we must rely upon the State estimates. The tone has been set with our request to the Congress this past January of \$2.3 billion shortage, that the States know better than we, at the national level, as to what the budget requirements should be.

As I mentioned, the problem has been the difficulty of summarizing, at the national level, the major factors that drive the budget costs. These new draft instructions that we've been working on attempt to address that problem.

We have used the State by State estimates for our current 1980-1981 budget cycle, with the commitment that we'll work with the States to better explain and justify the budget requirements and to explain the variances from our initial requests, when we do the budgets 18 months before the beginning of the fiscal year, to the revised and updated estimates.

There are wide ranging variances, State by State. In that period, for fiscal 1980, from your initial estimates to us, until the recent ones, there was an increase of about \$600 million, against a national budget appropriated for 1980 of \$12 billion.

Finally, a word or two on our status of the national Medicaid budget. First, for 1980, there is a pending supplemental that has had House action. That supplemental went up last January as part of the 1981 budget -- \$2.3 billion in addition to the \$12.4 billion already appropriated for 1980.

A few weeks ago, this supplemental passed the House in essentially the same amount as requested. Our request of \$14.7 billion, the revised estimate, is based on States' estimates. The House included, in the appropriation language, words that permit a two year limit on prior year claims, rather than the one year that was passed last fall.

Last week, the Senate Appropriations Subcommittee, in markup session, agreed with the House action on the amount requested, and it appears that they will also be attaching appropriation language to give relief to that one year limitation on prior year claims.

There is also language in a Congressional conference report that further broadens and gives relief to that one year limitation on prior year claims. That one might make it before our supplemental budget gets through the Congress.

For fiscal 1981, our budget is pending before the Congress, \$15.9 billion, based primarily on the February State estimates. We've given the Congress a State by State wrap up.

For 1982, of course, we're just starting a new budget cycle and that's the agenda item that we want to talk about. What we foresee happening this fall is HCFA followup on its commitments with the reviewing bodies of the national budget to do a better job, and to get you to help us do a better job in explaining what's driving these costs in the Medicaid budget.

MR. SCHREIBEIS: From my own personal point of view, logic or moral ethics or something would dictate that the bulk of the claims we have been trying to pay since last fall ought to be payable, and some time in the next couple of weeks or a month, we expect that to happen. I know that some States are running short of money because of it, and we're doing our best on that.

On the forms that Anna Perkins was talking about, we have set up this TAG, which is going to be meeting next week on May 21st, and I want to thank Howard Stansberry and Paul Allen for their help in setting it up. We have 12 States represented on the TAG. That may be a good number or may be too many, we're not sure. We'll see how it goes next week.

We have four regional people also in that TAG, and our first order of business is going to be to get the TAG group organized, to elect a chairperson for it, and to go through this package.

When the States see it for the first time, I guess it may look kind of drastic, because it's about 25 pages long, but only about 10 pages of that represents actual forms to be filled out; the rest of it is instructional material.

Once we have done our thing next week in the TAG session, we will be sending whatever modifications are made to it out to all the States for comment. We will, at the same time, be going to OMB and asking for their clearance of the form.

I don't know whether you are aware, but the existing forms that we use today have expired. So for the August submission, the normal quarterly submission, we will be using whatever new set of forms we and the TAG agree seem appropriate, with the understanding, between ourselves and OMB, that it's really a trial run and that we won't be serious about it until November, because that's the critical budget point in our national budget process.

So, between August and November, any thoughts that you have in terms of reporting requirements that are doable or not doable, will be taken into account.

In November, then, we should have a solid package that would be used in the future. This package is going to be a merger of today's HCFA-65 and OA-25, so that we will get a certification and a budget estimate in one document, and the principal difference between what we do today and what we will be doing in the future is that we are asking for more details of the assumptions that you are making in coming up with your budget estimates.

I don't think we're asking for anything that, in the normal budget process, you don't already have, in one form or another. What I'm talking about are factors like price assumptions, recipient population assumptions, utilization assumptions. You may have all three. You may have some mixture of the three. I know that some States have all three broken down by type of service, by type of beneficiary. These are considerations that we are going to have to work out over an extended period of time, because I would like to see, to the extent possible, some degree of uniformity in the way the States, themselves, look at the budget, at least in the sense that we're all touching certain basic points in common.

Other activities that we will have going on in the future with this Technical Advisory Group include looking at the administrative budget process of the States.

We would like to get more information on the number and types of people it takes to get a certain job done. We will also get into issues such as the cost of an MMIS system, the cost of intake eligibility enrollment activities, and how States go about doing these functions, and the different structures around the country in terms of cost allocation plans and procedures.

I guess what we're really saying is that we would like to better understand what makes up the States' fiscal process, both in terms of budget and in terms of its own internal activities, as they relate to our administrative expenses.

There are other issues also that we will be getting into. We've had a few issues coming out in the past couple of months on abortion, on third party liability, on a number of other issues. We've also had a number of questions coming in from States on FFP procedures, policy, etc., and we would like to get the TAG people involved in some of these questions because we believe that you folks know more about what's going on out there than we do, and we think that your input into this process and changing and improving this process is going to be very valuable to us.

In receiving the submissions for 1982, we expect to go onsite to some of the States during the August to November period of this year, having gotten this first input package on the new reporting format. We will go onsite, probably to the top ten States and, if possible, expand that to other States, using central office and regional resources.

We would like to sit down with the individual States, get into their budgeting or accounting departments and look at the system that develops the bottom line that we're dealing with.

As Anna Perkins said, we have made an observation over the past couple of years that, in aggregate, the States' estimates turn out to be better than assumptions we have made. On a disaggregated basis, however, some States are very accurate and others are off the mark by a considerable margin. We would like to know what it is that makes a State accurate, what is it that makes a State inaccurate; are there certain key elements within a process, or is it the process itself? Is there some outside influence that drives the variations in numbers?

These are the kinds of questions we're going to be looking at in studying, onsite, various State systems. And we would like to, when we discover something that seems to work very well, come to some conclusion as to whether it's transportable; that is, can State A take State B's process, or some elements of it, and do something to improve their own system.

This is a long term project. We're looking for your support. We will have the support of the members of the TAG, and I think, between all of us, some time in the next two years, we will be able to do a major overhaul of the financial process in the Medicaid program.

MR. FLINT: I'd like to first comment on Mr. Schreiber's statement that the current OA-25 has expired. It has not. Your submissions, that I hope you have already put in the mail, are due today in Washington. They are required on the old form. It's essential that this information get in because it will be the first time that fiscal year 1982 estimates will be submitted by the States. It will be at this point in time that your numbers will be included in the HHS budget cycle.

As Anna Perkins has pointed out, we have had some difficulty in selling our estimates as the budget cycle proceeds in Washington. One of the reasons for the difficulty has been the lack of information and detail in those estimates. Staff projections that were provided internally to HCFA for fiscal years 1979 and 1980 were on the order of 99.7% accurate for fiscal year 1979 and 99.3% accurate for fiscal year 1980.

The problem is that with a lack of backup detail, those estimates did not survive the budget process. The result was that we have a \$2.2 billion supplemental requirement to cover fiscal years 1980 and 1981.

Hence, this issue of understanding what's behind the estimates, that is, getting the assumptions, is extremely critical. Right now, I'd like to talk about the longer range aspects of what we're doing to improve forecasting.

What we'd like to do first, is to develop a forecasting tool that is more responsive to your management needs.

What would we like to do for Medicaid forecasting in the long run? We have a contract that has been let with the Actuarial Research Corporation in Virginia, to develop an actuarial basis for forecasting Medicaid costs on a State by State basis.

This contract was let because we're going to be using State estimates, and we know that there are wide variations in the ability of States to forecast. Also, a number of States have shown an interest in trying to develop and improve their forecasting capability. This contract will develop an improved basis for forecasting. In addition, it will provide us with a capability to make forecasts of individual State costs.

The project director for Actuarial Research Corporation may be someone you're familiar with, Gordon Trappnell. He's been an actuary with the Social Security Administration dealing with Medicare a number of years ago. He's also been under contract from the Department to make estimates for national health insurance and from the Senate Finance Committee to cost out Committee proposals in the health care financing area.

Our approach in this contract is to work with about 10 or 15 States in a several stage process. The States are yet to be identified but as a result of the financial IAG group and other activities, we will be identifying those States.

The intent is to take a look at the current state of the art, both in terms of forecasting methodology and the data bases that are used in forecasting. This will be for both MMIS and non-MMIS States. We will also look at what States perceive they need in order to improve their forecasting ability. Some of these needs we know. Others we'd like to know in order to understand what your individual problems and needs are to improve your forecasting capability.

Considering both your needs and ours, we then plan to develop a short term system that recognizes certain data limitations, but does provide some rudimentary capability for doing forecasting. This will be a system that will be compatible with what a longer range, more sophisticated system, that is actuarially based, can produce.

I would like to describe to you, in a very general way what the forecasting process is. You may feel that I am stating the obvious, but in many cases the obvious has to be said. Any forecasting system must start with data on historical program costs and program performance.

There are also demographic factors that relate to numbers of persons eligible for the program and there is economic information. All of these are used to develop a current services forecast; that is, without any assumptions about program changes, additions or deletions of benefits, additions or deletions of beneficiary groups, etc. These rates of change, applied to prior year costs at some level of disaggregation, will give you the forecast for the future year or years.

Obviously, though, there are times when there are other considerations. Additions or deletion of benefits may have to be considered based on budget guidance from higher levels within the State agency in order to meet certain budget restrictions; or there may be additions to the program. You then introduce the impact of these program changes into your forecast. These are overlaid on top of your current services estimate and this becomes your budget request.

Our forecasting contract will first look at the levels of detail of data now being used by States in their current forecasting operation. Then we will identify what individual States believe their data requirements are for their own budgeting purposes. For our own needs, we will examine to what extent these more detailed needs could be collapsed into a level that is appropriate at the Federal level. We will take a look at the States' current ability to analyze historical data, and take a look at what could be done for the State to improve their capability and see how that could fit in with the broader Federal budget estimating needs.

Quite clearly, the success we have with this contract depends on your participation and your identification of your forecasting needs. I think there's no question that we will not have an effective tool unless this is a tool that can be useful to you, at your level, in your State, for developing your budget estimates.

It will not work if we try to impose a system which every State must follow in addition to what is currently done by States in developing the budget where our system becomes an extra burden.

This contract is over a two year period. I would caution you not to expect immediate results. On the other hand, we felt that it was important to let you know about what we are doing, so that we can get your early input in the development of an improved forecasting capability. In closing, I'd like to leave you with one more thought. I think a lot of us are frustrated, perhaps at both the State and Federal levels, as to what is perceived as a totally disorganized budget process. Hopefully, through this effort, we can get a better system that will produce more useful information and we will be able to improve our estimates and consequently our images, both at the State and the Federal level.

MR. ALLEN: I think the budget process in Michigan is no different than it is in any other State and in the Federal government. There are many characters in the drama. There are many real and many imaginary numbers used in the process.

The characters in the drama, of course, start with the program manager, who's at the bottom of the heap and usually has the real information; I mean what is really the budget need.

Then, layered on top of that, of course, are the department's or umbrella agency's budget office. Then the executive office budget office and then the legislature. As budget plans progress through this hierarchy, we start playing with imaginary numbers. And, I must admit there are rational and logical reasons in each State for these imaginary numbers.

But, on the other hand, many of the numbers that come out of these processes are political numbers and aren't necessarily the ones that you would want to hang your hat on if you were the budget person in Washington trying to justify an aggregated budget for the total Medicaid activity.

So, I think we all appreciate each other's problem, it determines the right budget numbers, and the States are more than willing to participate in the Federal budget process. We just want to make sure that the product that comes out of the financial technical advisory group and HCFA is one that is not overly complex, and that we can all adhere to in a very rational way.

I hope that the meeting next week, and some of the past discussions of recent note, would allow us to zero in on the gut factors that you need to come up with a better product. We, like you, would like to have more credibility when we generate these numbers and, in turn, more Federal financial support.

In the State of Michigan, we have had extensive cost containment activity in the past year and we'll have more in the future, as the economy bottoms.

The problem with cost containment is that it does, among other things, influence the budget requirement number that is eventually generated and given to the Federal agencies. The degree of influence varies by State.

Because of HCFA questioning, we've taken some hard looks at the many factors bearing on the numbers we give you, and, frankly, cost containment in Michigan is a very small number when you view it in the aggregate of the amount of the budget.

To illustrate the point, our budget this year is a little over \$1 billion for Medicaid and our cost containment goal this year is \$23 million of that \$1 billion plus. So, as a percent, it's very small, and if there was any variance in that, it wouldn't be noticeable in the aggregate.

On the other hand, I think all of us spend most of our money in three basic areas: long term care, hospitalization, and physicians' services. To the extent that we can determine utilization factors, recipient eligibility data, scope of benefits information and inflation factors, I think we should be able to give you the essential information you need, so that your number is a little closer in its projection to what it actually turns out to be.

I think that during the last two years the disparity between your estimate and the real world was exacerbated by some decisions made in Washington to give undue credit to any cost containment activity or fraud and abuse activity, and that's why you wound up with a \$2.2 billion supplemental.

I won't try to, in any way, denigrate your activities to improve budget forecasts. We're supportive of it. In this regard, we'll do the best we can to try to achieve some standardization and common reference points.

Questions?

MR. WILLIAMSON: I think that we, in HCFA, have learned a little bit, over the last couple of years, about the budget process, and your reference to some of our estimates. I think that we're now moving in the right direction. We've got a pretty good structure set up now, in terms of working with you in developing these budgets. I think the revision in the 25 and the 65 is going to be very helpful to you and to us in the long run in building our budgets, the work that would have to be done in this area, in my view, is going to take a couple of years in terms of working at all of these issues.

COMMENT: I don't really have a question, I just have a comment to make in reference to the discussion and that is to say that it's not always easy for the States to project their own budgets, because there are many mitigating factors at the State level, and when you multiply that by 50 jurisdictions, you multiply that factor.

For example, in the State of New Jersey, we know, for our next fiscal year, the amount of funds that we need to continue our program at its present level. However, in the budget process, we are being short funded by about \$25 million in State funds, so that we know that we are going to have a deficit going into next year, from the very first day.

Other factors that don't even come into this whole budget projection are court decisions and litigations that are pending that, depending on which way they go, can cost the State millions of dollars in the many cases these court decisions mandate the expenditure of funds. This forces the State, and many times during the middle of the fiscal year, to have to relook at its budget picture and either reallocate funds from some other department or some other source within the State structure, or to have the legislature come back and vote for supplemental appropriations, if that's necessary.

So these are all unpredictable factors that can throw a State's budget projection off by very large amounts.

MR. WILLIAMSON: I think you make a very good point. I guess if we took the Federal budget process and just looked at that, and multiplied it many times, you'd get the same picture in terms of what's going on over on the Hill.

MR. FLINI: I'd like to react for a minute to the comment about re-looking at the budget. We certainly recognize that there are a lot of unknowns when you develop a budget. It has been pointed out that there are many variations, plus and minus, and that these are compounded by other States.

In fact, a particular phenomenon has occurred with the State estimates that doesn't compound the "error". We have enough different State estimates that are put together independently such that over and under estimates tend to cancel each other. Statistically, the rule of large numbers applies. Even though there's great variation in individual States, the error nationally is not as great as the sum of all the States because these "errors" are off-setting.

What we are concerned about are the cases where the State estimates that have been provided turn out to be significantly incorrect: 20 or 25% understated, or in some cases, there have been overestimates of more than 60 or 70%. I think we could achieve a significant improvement in the order of magnitude of the overall accuracy. We should look at the reasons for these very major large differences first. Then, if the rule of large numbers still applies, it will mean that we've looked at an equivalent number of over and under estimates so that the national estimate, when aggregated, will be even more accurate than it has been in the past.

COMMENT: I'd just like to compliment you on the approach that you're taking. I think that you're building from the correct base, where the States are coming from and what kinds of things they have to deal with on a day to day basis in evolving their budgets.

It's a much more complex approach than other units of the Federal government have tried to deal with in their development of approaches, and I really applaud you in making this kind of an effort.

The technical assistance that you're intending to provide also has the unique value of benefiting both the State and yourself, so another plaudit.

CLOSING REMARKS

Mildred L. Tyssowski
Former Director
Bureau of Program Operations
HCFA
Baltimore, Maryland

MRS. TYSSOWSKI: In closing, I'd like to say that I hope you have found this conference worthwhile and enjoyable. The agenda represented what we think are topics of current concern and emphasis in HCFA and in the total State-Federal administration of the Medicaid program.

Also, we have indicated that we're interested in your views as far as the directions in the administration of the Medicare and Medicaid programs, both in the immediate future and longer range.

I want to say that we certainly have taken note of the request of the Association to participate in long term care planning at the HCFA level. We will be talking this request over with our Administrator and, more particularly, Deputy Administrator Collier, who is the Chairman of the HCFA Task Force.

Also, we have agreed to the establishment of a Technical Advisory Group on long term care.

We've also taken note of your concerns about common claims forms. I detect that there's no one who disagrees with the concept; rather, it's just a question of the degree of flexibility that can be maintained and still achieve the concept of common claims forms.

This conference has really been noteworthy from other perspectives. You've changed your name to the State Medicaid Directors' Association and decided to affiliate with the American Public Welfare Association. There has also been a change in leadership. I want to publicly thank Glenn Johnson for his cooperation and assistance.

I also want to congratulate Paul Allen for taking on the new post as the head of your association. Paul has been, over the years, extremely helpful and a very good advisor to HCFA. And so, Paul, I look forward to working with you in the future in your leadership of this organization.

I agree with Glenn Johnson's earlier remarks in that this conference has been a very positive experience toward developing better Federal and State relations.

I would also like to take this opportunity to thank Mary Kenesson and her staff for all the work that she and her staff have done to manage the conference, develop a good agenda, and certainly to make the whole conference run very smoothly.

WORKSHOP SUMMARY REPORTS



Key Issues/Points Discussed

Medicaid Minimum Data Set (MMDS):

- o HCFA identified need for consistency in definitions of data elements. As such, current report forms preclude effective aggregation of similar data.
- o Status of States' activity noted that there are approximately 20 States reporting MMDS data.
- o A consulting firm, Compass Management Group, Inc., 1200 112th Avenue, N.E., Suite 160, Bellevue, Washington 98004 - (206) 454-8328, is available to lend States technical assistance in implementing the MMDS requirements. Contact should be made through the following HCFA representatives, Charles R. Owen, Director, Division of Reports and Analysis, Office of Standards and Performance Evaluation, Bureau of Program Operations, Baltimore, Maryland - (301) 594-8100.

Surveillance and Utilization Review (SUR):

- o HCFA believes that there should be more comparative analysis of Medicare and Medicaid paid claims data. In order to accomplish this, HCFA has created within BQC the Office of Systems Analysis under the direction of Jim Fraher (301-597-1898). This office will, among other activities, request paid claims files from Medicaid State agencies and Medicare contractors in order to compare payment histories on provider activities in both programs. BQC believes this will identify providers who may require indepth review. These providers will be referred to BQC's Office of Program Validation for onsite review if appropriate. In addition, this activity may be useful to the State agencies and the Medicare contractors in evaluating their post payment utilization review procedures.

Medicaid Management Information System (MMIS):

- o HCFA will distribute MMIS changes to the States before finalizing. Input and recommendations from "interested" organizations is invited.

States' Concerns/Questions

Management and Administrative Reporting System (MARS):

- o Several States noted dissatisfaction with current report forms. They announced that they are attempting to develop improved forms that will provide for a more:
 - Flexible data base
 - Effective management reporting system

- o One State noted several examples of data elements that should be included on the reports if they are to be more effective as management tools in evaluation of health care delivery systems. These include, for example:
 - Identification of type of program service, e.g., hospital, nursing homes, family planning, home health, transportation, etc.
 - Location of performance of service, e.g., hospital, nursing home, etc.
 - Identification of therapeutic treatment, e.g., hypertension, eye care, injection, surgery, etc.
 - Notation of diagnosis, e.g., mental disorder, coronary disorder, diabetes, etc.

Recommendations/Actions to be taken

States were invited to submit suggestions to HCFA regarding improving SUR and MARS report forms.

Recorder: Don Allen
Branch Chief
Corrective Actions Projects
Division
Medicaid/Medicare Management
Institute
Bureau of Program Operations/HCFA
Baltimore, Maryland

Key Issues/Points Discussed

Title V and Title XIX have negotiated an agreement as to first dollar responsibility regarding use of Title V agencies to provide EPSDT services. Will test in Colorado.

CHAP included in Executive and House budgets for fiscal year 1982, but was dropped by the Senate.

Consideration should be given for using schools for outreach and case management.

Michael A. Gelder & Associates awarded a contract to establish a communication network among States.

Other contracts are being considered regarding outreach and local case management.

Contract has been let in Kentucky and California to National Institute for Advanced Studies, for 18 months, on May 1, 1980, for the development of an EPSDT system.

QC/EPSDT interface project:

- o Field tested in 10 States during January and February 1980.
- o Manual revised so reviewer will have less judgments to execute.
- o Advisory group reviewed manual.
- o Manual release: 1st section released June; 2nd section tentative for September.
- o Plan to train Federal staff in June and September.
- o Review of administrative requirements planned for some time in July through September.
- o Informing requirements will be reviewed October through December.
- o Screening and treatment requirements will be reviewed some time between January through March 1981.

States' Concerns/Questions

Regulations too process oriented.

States should not be held accountable for circumstances over which they have no control.

Regarding provider of choice requirement, States should be allowed to designate which providers are qualified to participate in the EPSDT program.

Requirements for face to face informing and furnishing written information about EPSDT within 60 days of AFDC eligibility determination date not always appropriate or effective.

Documentation requirements too detailed.

Mandatory dental requirements can cause increases in program costs. Too many dentists will not see/treat children under 5 years of age. The lack of "enough" Title XIX participating dentists in some areas precludes the delivery of adequate EPSDT services.

HCFA should implement waivers of specific requirements for States who have been determined to have a superior method for performing an activity.

There is a general agreement among the States that HCFA does not really listen to them.

Federal Concerns/Questions

In response to States' concerns/questions, Federal staff explained:

- o Providers should not be excluded from participating because of their type of practice. The original concept of the EPSDT program of encouraging providers to participate should be followed.
- o There is consensus among the Federal community that face to face informing and the furnishing of written information is necessary if the EPSDT program is to be more effective in reaching eligible recipients.
- o HCFA supports mandatory dental services.
- o Consideration is being given by HCFA to seek legislative authority for issuing waivers for States determined to have implemented a "superior" practice or at least for "good faith" effort.

Recorder: Edward Neuschler
Program Analyst
Division of Medicaid and Long
Term Care Policy
Office of Policy Analysis
Office of Legislation
and Policy/HCFA
Washington, D.C.

Key Issues/Points Discussed

Current issues and plans for integrating performance standards with State assessments:

- o HCFA's role as trustee of the Medicaid program.
- o HCFA's responsibility to measure how effectively States manage their programs.
- o HCFA does not have authority for establishing incremental reimbursement based on outcome of State assessments. Legislation is before Congress.
- o State assessments should be more frequent than every 2 years.

Performance standards design:

- o Need uniformity in performance standards and in their use.
- o Publish annual reports that focus on problem areas.

MMIS certification and recertification issues:

- o Revision of current standards with STAG input.
- o Standards should identify initial certification and recertification.
- o Develop method for scoring results.

State participation in development of State assessments/performance standards:

- o Performance standards will offer States increased accountability and opportunity to improve their programs.
- o Unless States make data available, performance standards will not be effective.
- o A negotiated review process should be used.

Regional office activities:

- o Need to ensure effective use of staff in view of existing staff limitations.
- o Establish procedures to avoid duplicate requests for data.
- o Keep States informed of review results.

States' Concerns/Questions

Performance standards should be meaningful measures which identify good and poor performance.

HCFA should avoid duplicate requests for data from different units.

State staff resources are limited. HCFA should remember this when making requests of State agencies.

Allow States time to respond to deficiencies before applying penalties.

State assessments are often performed too late for States to use findings before State legislatures to support their request for additional resources.

Federal Concerns/Questions

Recognizes need to:

- o Make performance standards meaningful.
- o Avoid duplicate requests for data. Feels, however, that this cannot always be prevented.
- o Concentrate on identified problem areas.
- o Apply performance standards uniformly.

Recorder: Fred Eustis
Program Analyst
Improvements Management Staff
Medicaid/Medicare Management
Institute
Bureau of Program Operations/HCFA
Baltimore, Maryland

Key Issues/Points Discussed

Diversity of State-by-State Medicaid populations are more difficult to reach in comparison to a single Medicare community.

To improve beneficiary understanding of Title XIX, it is necessary to make certain that the information provided is timely, useful, and accurate.

Need for HCFA and State Title XIX agencies to assess their management of the Medicaid program to create opportunity for improving the delivery of medical care and services to beneficiaries, and to produce an increase in beneficiary responsibility.

National Health Law Program (Washington, D.C.) commented:

- o Increase focus on problems associated with beneficiaries' access to health care and services.
- o If necessary, appropriate consumer groups should consider the possibility of litigation to contest cutbacks in amount, duration and scope of services.
- o Promote organized recipient protests through hearings or appeals processes by affected client population when there are reductions in program benefits.
- o Explore potential for lowering program costs through use of available options to save State monies and as a result, bring in more Federal matching/funding, for example:
 - Ribicoff children's option
 - Unborn children's program
 - Limiting costs associated with long term care
 - Alternatives to institutionalization
- o To increase provider participation, have institutions, as a requirement for certification for participation under Title XVIII and Title XIX, require that staff physicians treat Medicaid and Medicare beneficiaries.

States' Concerns/Questions

In considering improvements in beneficiary services, States should focus on areas where they have face to face contact with beneficiary issues, such as:

- o Eligibility process
- o EPSDT outreach, screening and followup
- o Caseworker efforts in relating to beneficiaries
- o Prior approval process
- o Preadmission screening, particularly in LTC settings
- o LTC medical review
- o Utilization review mechanisms
- o Fair hearing process

Establish a clearinghouse for publications on improving services to beneficiaries.

Cutbacks in ambulatory care services are ineffective. They can result in increase in beneficiary institutionalization.

Federal Concerns/Questions

HCFA public information activities include:

- o Television, films and radio spot announcement on EPSDT outreach. Currently being tested in Seattle, San Francisco, and New Jersey.
- o Self help program for the elderly. Information about access to care.
- o How to choose a nursing home.
- o Second surgical opinions:
 - Discussion and analysis of statistics and projections
 - Promotion of individual responsibility
 - Testing waiver of copayments in New York and Detroit
 - Media spots in cities where percentage of procedures are higher than national average. Will later review/measure impact of promotion of information.

Promotion of use of HMOs in Medicaid:

- o Exploring problem of eligibility changes that preclude long term participation.

HCFA actions being undertaken to promote the improvement of services to beneficiaries include:

- o Development of baseline information and collection of data on HCFA programs
- o Analysis of provider participation
- o Setting national program goals
- o Evaluation of research and demonstration expenditure impact on beneficiary activities
- o Redefining quality control (QC) to include quality as well as dollar measures.

Recorder: Bernard Freeze
Acting Branch Chief
Improvements Promotion Division
Medicaid/Medicare Management
Institute
Bureau of Program Operations/HCFA
Baltimore, Maryland

Key Issues/Points Discussed

Public Health Service perspectives on HMO contracting:

- o Good business for State agencies to contract with HMOs.
- o HMOs can:
 - Reduce costs of providing health care and services.
 - Deliver better quality care.
 - Provide more efficient administration of health care programs.
 - Serve a representative population of all groups.

States' Concerns/Questions

Impediments States face when contracting with HMOs include:

- o Lack of understanding about HMO procedures and concepts.
- o Delay in payment for services.
- o Intermittent eligibility of recipients.
- o Too many complex State and Federal regulations.
- o Difficulty in marketing HMO concept with Medicaid recipients.

Recommendations to counter impediments facing States:

- o Introduce legislation which would provide incentives for individuals to join HMOs and facilitate the marketing process.
- o Emphasize the use of a HMO card rather than a public assistance card to avoid embarrassing the recipient.
- o Contact recipients immediately after becoming Medicaid eligible. Can be accomplished by:
 - Caseworker
 - Direct mail
 - Films and public information brochures
 - HMO marketing representative

- State agency representatives.
- o Extend period of eligibility.
- o Minimize program administration to avoid multiple agency administration of HMO contracts.

Federal Concerns/Questions

HCFA's Group Health Plans Operations Staff initiatives to assist States and regions in promoting HMO and prepaid health plan contracts under Medicaid:

- o Training sessions for HCFA regional office staff.
- o Publication of annotated bibliography which describes effectiveness of HMOs from a service and cost viewpoint.
- o Revision of HMO section of Medical Assistance Manual.
- o Outline and summary of contracting regulations.
- o Contracting with a firm to provide actuarial assistance to States.
- o Encouraging qualified HMOs to seek State contracts.
- o Establish a HCFA/PHS workgroup to promote Medicaid HMO contracts and enrollment.
- o HCFA should consider legislative changes to promote HMO Medicaid contracts (waive 50/50 rule for HMOs, cost contracts for HMOs, etc.).

Recorder: Keith Dryer
Director
Regional Liaison
Bureau of Program Operations/HCFA
Baltimore, Maryland

Key Issues/Points Discussed

Current program status includes 183 PSROs participating with an expected review of 11 million discharges by end of year.

Program priorities:

- o Fully implement acute hospital review, including ancillary and physician services review.
- o Increased implementation of PSROs performing long term care is a secondary priority. Currently, 54 PSROs are involved in this activity.
- o Establish improved review methodologies including appropriateness review.
- o Promote review methodologies that increases system economy without loss of effectiveness.
- o Coordinate and integrate PSRO activities with other organizations that have a role in health care delivery systems.

1979 PSRO program evaluation findings (based on 1978 data):

- o Overall reduction of 1.7% in utilization of Medicare days of hospital care in active PSRO areas. Reduction varied with regional areas.
- o A pilot Medicaid hospital utilization rate study was conducted. Results did not establish utilization trends nor permit assessment of PSRO impact. It did enable analysis of problems associated with analyzing Medicaid data.
- o A quality of care study indicated that medical care evaluation studies (MCEs) were having a significantly positive effect on how physicians practice.

States' Concerns/Questions

A panel member noted Michigan Title XIX State agency:

- o Is using MMIS data to evaluate PSRO performance.
- o Has not noted any observable positive impact of PSRO review at this time and has found PSROs generally unable to respond to State agency needs, such as its second surgical opinion and preadmission testing programs.

- o Has developed a newly approved monitoring plan which utilizes a desk audit approach.
- o Has declined to negotiate memoranda of understanding (MOUs) for PSROs to begin Title XIX long term care review.

A panel member, Kentucky Peer Review Organization, noted that Medicaid agencies can benefit from PSRO review through:

- o PSRO assumption of State's utilization review and utilization control costs.
- o Reduced Medicaid paperwork.
- o Reduced political pressure on Medicaid agency.
- o Reduction in hearings.
- o Increased ability to improve physician practice through physician to physician contact.
- o Increased cost consciousness of physicians.

Did length of stay evaluation look at the readmission problem? Yes, the use of total days of care as a basis for evaluation incorporate readmissions.

When computing the cost benefits of inpatient days saved, was an adjustment made for the greater cost of the first few days of an admission compared to the final days? An average per diem was used.

How will ambulatory care review be evaluated? It will depend on the mechanism used to review ambulatory care.

Do HCFA and the Congress want the PSRO program to survive? Aren't certain studies being done too soon? The Department and HCFA have a genuine and strong commitment to the PSRO program. The reaction in the Congress is mixed, there being supporters and detractors. There is concern that these studies might be being done before the program is sufficiently mature.

Recorder: Lois R. Seidler
 Public Health Analyst
 Division of Program Operations
 Office of Professional Standards
 Review Organization
 Health Standards and Quality
 Bureau/HCFA
 Baltimore, Maryland

Key Issues/Points Discussed

OMB Circular A-102, Attachment O, codified as 45 CFR Part 74, Subpart P, requires State agencies to procure fiscal agents through competitive bidding.

Only HCFA can monitor States' procurement. When HCFA finds a State out of compliance, DHHS can take exception, require prior approval of the contract, and require notice to the Secretary with respect to contract initiatives.

HCFA commissioned a study, available to the States, which reviews States' current fiscal procurement processes and provides guidelines and recommendations for more effective procurement. The study:

- o Is entitled "Final Report and Program Models for Medicaid Contracts with Fiscal Agents."
- o Found that States had no organized approach to procuring fiscal agents and needed procedures for effective procurement.
- o Also found that contracts should not differ from the RFP and should consist of the following:
 - A cover sheet
 - The request for proposal (RFP)
 - The contractor's bid
 - A list of changes from the RFP
- o Found that the contract should be rebid if there are major changes from the RFP since changes are the most common reason for lawsuits.
- o Divided the procurement process into five functional areas:
 - Feasibility study
 - RFP
 - Proposed contract
 - Statement of award
 - Performance and evaluation criteria

- o Showed that effective contract administration depends greatly on the quality of the RFP and both the States and HCFA regional offices require more guidance in writing RFPs effectively.
- o Showed that in those States where the program office handles procurement, the procurement process tends to be smoother than in States where the procurement process is removed from the program office and from the area of expertise.
- o Further indicated that both the States and Federal government should reconsider the idea of an annual price change based in part on the Consumer Price Index (CPI).
- o Noted that contracts that are written too specifically hamper innovative contracting techniques. However, where possible, the contract language used should be specific, and not vague.
- o Indicated that in defining contract specifications, the State should consider a line item price in addition to a per claim price. Pricing items separately simplifies the evaluation of the contractor's requests for additional funds to comply with the State's ad hoc requests.

States' Concerns/Questions

The value of open competitive bidding and whether a change of fiscal agent necessarily means improved service. Response: Open bidding is an issue of a State's administration of Title XIX. States can evaluate quality by developing performance standards.

There is no way of measuring performance. The Federal government should measure performance so that a State which is satisfied with its present contractor could forego rebidding. Response: The GAO requires periodic competitive bidding. The State can measure performance by results. Regulations require that contracts be for a specific period (42 CFR 431.503) and that grantees seek free and open competition (45 CFR 74 Subpart P). The length of a contract can be discussed and negotiated, but it cannot be open ended. Presumably, exceptional contractors will have an advantage in any periodic competition.

New Federal regulations sometimes necessitate unforeseeable changes in the contract with the fiscal agent, for example, the MQC expansion project. This creates problems with States' monies allotted for program costs. Response: States should try having budget line items for contract changes. If States advise contractors that line items can be added to the budget, a contractor may decrease the price of the contract since a contractor probably adds money for unexpected costs to its estimate. States can also use a pool process with a cap on it as was done by State agencies in one Federal region. The pool, however, must be limited to inconsequential changes.

HCFA was asked about its position on selecting the lowest bidder. Response: "In a negotiated procurement, proposals are first evaluated in the technical, experience and cost areas to determine which proposals would fall within the competitive range. Then, price, technical or other aspects of a proposal could be negotiated and all offerors remaining in the competition are advised of the areas of discussion. After negotiations, all offerors in the competitive range would be permitted to submit a best and final offer making any changes they wish to their proposals. The award is then made, based on all evaluation factors, and it may or may not be made to the proposal with the lowest offer."

Federal Concerns/Questions

HCFA is beginning to address the problems of State procurement of fiscal agents and needs input from States on their problems. There is concern as to whether States are aware of Federal standards in reviewing procurement procedures. HCFA will establish an inventory and a central control of fiscal agent contractors which States have entered into.

Additional Comments/Observations

Currently, in theory at least, States can procure a contractor and the Federal government can reject the contract.

States want to work with the Federal government in procurement and recommend that the Federal government do the following:

- o Develop a series of packages to assist the States in the procurement process.
- o Become involved early in the procurement process and to work closely and continuously with the States.
- o Provide greater guidance to the States in monitoring and controlling the contractor.
- o Develop guidelines that will assist States in procurement actions.

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WORKSHOP ON LONG TERM CARE

Key Issues/Points Discussed

Long term care is a priority concern to those involved in the delivery of medical care and services - Federal, State and private communities.

There is need for a mechanism to enable systematic program assessment of:

- o Current program needs and what is needed to meet them
- o Past program efforts and benefits realized
- o Present program activities to inventory those in progress and at what level

Department of Health and Human Services' effort to improve the delivery of long term care services includes:

- o An Undersecretary's task force with administrative and coordination responsibility in the Office of the Assistant Secretary for Planning and Evaluation (ASPE). Currently the task force is:
 - Examining all areas of long term care and possible fragmentation of the program to identify and address major problems and cross cutting issues.
 - Researching the possibility of separating long term care from existing programs and establishing a new title.
 - Exploring the possibility of program improvement through increase in individual providers/organizations.
 - Subject to the availability of Federal monies, planning to spend \$20,000,000 over next five years, divided between the Health Care Financing Administration and the Administration on Aging, to explore new ways to keep people out of long term care facilities.
 - Subject to the availability of Federal monies, there is consideration for developing alternative approaches for existing family care. In line with this, RFP development includes the following proposals:
 - . Evaluation on a national scale
 - . Provision of technical assistance
 - . A national data base

- The State directors were invited by ASPE to submit recommendations and engage in two way discussion of innovative approaches for improving the delivery of long term care services.
 - HR 6194, Medicare and Medicaid Community Based Services (Mr. Claude D. Pepper, D-FL and Mr. Henry A. Waxman, D-CA), was described. More often referred to as the Community Care Act of 1980, the focus of the presentation was on the amendment of Title XIX of the Social Security Act to provide for comprehensive assessment and community based services under Medicaid.
- o The Health Care Financing Administration's Long Term Care Policy Group, chaired by Mr. Earl M. Collier, Jr., Deputy Administrator, HCFA and vice chaired by Tera S. Younger, Deputy Regional Administrator, Region I, HCFA, followed with a description of their activities in the area of:
- Issues that require immediate decision
 - Long range recommendations
 - Their role as the HCFA focal point for relating to the Undersecretary's task force
 - Immediate issues impacting the delivery of LTC services, such as:
 - . Protection of patient's funds
 - . Home health
 - . Fraud and abuse
 - . Regulations impacting the quality of long term care services
 - . Reimbursement
 - . Medicaid coverage of patients with mental illnesses
 - . Level of care determinations
 - . Program regulations guides on program participation during an appeal
 - . Status of research and demonstration activities

- o A brief discussion on LTC reimbursement followed. This included, in addition to a description of the organization of the Division of Alternative Reimbursement Systems and its relationship to HCFA, Sen. David L. Boren's (D-OK) proposed legislation that:
 - Deletes the requirement that rates be set on a reasonable cost related basis. Rates would be developed based on meeting the cost of an efficiently and economically operated facility.
 - Changes the Department of Health and Human Services process for approving LTC plans.

States' Concerns/Questions

The State Medicaid Directors' Association noted the establishment of a Long Term Care Committee chaired by Mr. Jack Knowlton, Director, Division of Medical Assistance Program Development, New York State Department of Social Services as

- o The long term care survey conducted by the Association was discussed. See survey form and tabulation of data from States as of May 1980, following this summary.
- o It was noted that the committee will work closely with parallel issues of the American Public Welfare Association (APWA). The committee will meet June 24, 1980, in Denver, Colorado, in conjunction with the quarterly meeting of the National Council of State Public Welfare Administrators, American Public Welfare Association (APWA).

Federal Concerns/Questions

Important to consider program changes carefully. Impact of change can decrease States' capability to provide adequate medical care and services to eligible recipients. For example, premature emphasis on deinstitutionalization can create need for other types of services not available in some areas - home health agencies, health maintenance organizations, etc.

Concern over the impact on LTC facilities of efforts to deinstitutionalize the retarded and mentally ill.

How we can achieve a decent quality of life for persons who need LTC services on a chronic basis is being explored.

Lack of sufficient monies can impact the effectiveness of Title XIX. For example, plans to alter reimbursement levels can result in a decrease in provider participation.

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LONG-TERM CARE SURVEY

State: _____

Please supply the following data relating to long-term care resources and utilization in your state for the period January 1, 1978 - December 31, 1978.

- a. Total number of nursing home beds: _____
- o Number of Skilled Nursing Facility (SNF) beds: _____
 - o Number of Intermediate Care Facility (ICF) beds: _____
 - o Number of Intermediate Care Facility-Mentally Retarded (ICFMR) beds: _____

- b. Total number of home health agencies: _____
- o Number of proprietary home health agencies: _____
 - o Number of not-for-profit home health agencies: _____

- c. Total number of residential care facilities: _____
- o Total number of beds in residential care facilities: _____

- a. Total number of Nursing Home Patients: _____
- o Number of SNF Patients: _____
 - o Number of ICF Patients: _____
 - o Number of ICF-MR Patients: _____

- b. Total number of Home Health Care Patients: _____

- a. Nursing home expenditures:
(Please complete to the degree possible)

<u>Payment Source</u>	<u>Number of Patients</u>	<u>Days of Care</u>	<u>Total Expenditures</u>
Medicaid	_____	_____	_____
Medicare	_____	_____	_____
~~Other~~ Third Party	_____	_____	_____
Private Pay	_____	_____	_____

- b. Please list average and maximum per diem reimbursement rates for SNF's, ICF's and ICF-MR's.

- c. Total home health care (e.g. nursing care, home health aide, various therapies, etc.) expenditures:

<u>Payment Source</u>	<u>Number of Patients</u>	<u>Total Expenditures</u>
Title XIX	_____	_____
Title XX	_____	_____
Other (please specify)	_____	_____
Subtotal: (unduplicated count)	_____ Subtotal:	_____

- d. Total personal care services (e.g. assistance with the activities of daily living) expenditures:

<u>Payment Source</u>	<u>Number of Patients</u>	<u>Total Expenditures</u>
Title XIX	_____	_____
Title XX	_____	_____
Other (please specify)	_____	_____
Subtotal: (unduplicated count)	_____ Subtotal	_____
Total Home Care Expenditures		_____

4. Does your state reimburse for personal care services? If so, what is the definition of "personal care services" utilized in your state? Under what general heading are these services reported to HCFA? (Please attach copies of any legislation, regulation and/or codes relating to personal care services.)

5. a. Are patient assessments (e.g. pre-admission screening, etc.) required for entry into institutional long term care? ' yes _____ no _____

If so, are assessments required for: _____ Medicaid patients _____ Other patients?

Who performs the assessment _____

Are assessments: _____ limited to medical criteria or _____ comprehensive (e.g. include social and environmental factors as well)?

(Please attach copies of any patient assessment forms used in your state.)

b. Are patient assessments required for admission to home care services? yes _____ no _____

If so, are assessments required for: _____ Medicaid patients _____ Other patients?

Who performs these assessments? _____

Are assessments: _____ limited to medical criteria or _____ comprehensive?

(Please attach copies of any patient assessment forms used in your state.)

6. Has your state initiated any programs/projects designed to provide alternatives to institutional long-term care for the chronically-ill, other than programs of regularly funded (Titles XIX or XX) home health care for personal care services? (If so, please describe the scope and size of the program(s) and attach any relevant materials which describe, evaluate, or otherwise refer to these programs.)

If so, are these programs funded through:	<u>YES</u>	<u>NO</u>
Special federal funding (e.g. 1115 or 222 waiver projects, etc.)	_____	_____
Regular Title XIX funding	_____	_____
State funding	_____	_____
SSI payments of participants	_____	_____
Other funding (please specify) _____		

7. Eligibility

a. Is your state one that provides Medicaid eligibility to:

- o All SSI recipients ("1634" or Title XVI states) _____
- o only those SSI recipients who meet more restrictive eligibility criteria for the aged, blind, and disabled (209(b) states) _____

b. If your state is a 209(b) state, what are the eligibility criteria used for the aged, blind, and disabled?

c. Does your state provide Medicaid coverage to the following optional groups?

YES

NO

- o Individuals eligible for but not receiving cash assistance. (42 CFR 435.210) _____
 - o Individuals who would be eligible for cash assistance except for their institutional status (42 CFR 435.211) _____
 - o All Individuals receiving only optional state supplements (42 CFR 435-230) _____
 - o Some classification of individuals receiving only optional state supplements, but not all such individuals. (42 CFR 435-230) _____
- If yes, please identify which classifications:

YESNO

- o Individuals in institutions who would not be eligible for cash assistance if they were not institutionalized but whose income is not greater than 300% of the SSI benefit amount payable under Section 1611 (b) (1) of the Social Security Act (42 CFR 435.231, 435.722 and 435.1005)

- If yes, please specify the income ceiling used both in dollars and as a percent of the SSI benefit amount payable under section 1611 (b) (1):

8. What changes in federal legislation and/or regulation do you believe necessary for your state to better meet the long-term care needs of residents of your state?

9. Did implementation of Section 249 of PL 92-603 (requiring cost-related reimbursement of nursing homes) strengthen or weaken your states' ability to contain costs? What changes, if any, would you recommend in this provision?

Contact Person for Survey Follow-up:

Name: _____

Title: _____

Address: _____

Telephone: _____

Date Survey Completed: _____

COUNCIL OF STATE MEDICAID DIRECTORS

LONG TERM CARE SURVEY (as of 5/80)

I. INSTITUTIONAL RESOURCES

<u>State</u>	<u>*Total Nursing Home Beds</u>	<u>SNF Beds Number</u>	<u>% All Beds</u>	<u>ICF Beds Number</u>	<u>% All Beds</u>
New York	98,128	69,937	71.3%	28,191	28.7%
Texas	96,549	15,983	16.6	80,566	83.4
Illinois	86,319	42,763	49.5	43,556	50.5
Ohio	59,228	NA	NA	NA	NA
Wisconsin	50,810	45,114	88.8	5,696	11.2
Michigan	46,544	33,038	71.0	13,506	29.0
Florida	33,943	32,116	94.6	1,827	5.4
Iowa	29,793	793	2.7	29,000	97.3
New Jersey	27,395	24,406	89.1	2,989	10.9
Connecticut	22,900	19,953	87.1	2,947	12.9
Tennessee	21,940	2,334	10.6	19,606	89.4
***Alabama	19,955	13,915	69.7	6,040	30.3
Nebraska	19,394	2,720	14.0	16,674	86.0
North Carolina	18,635	8,508	45.7	10,127	54.3
Arkansas	18,489	8,806	47.6	9,683	52.4
Virginia	18,085	1,719	9.5	16,366	90.5
Maryland	17,674	9,284	52.5	8,390	47.5
Kentucky	16,136	4,847	30.0	11,289	70.0
Oregon	13,685	3,581	26.2	10,104	73.8
**Mississippi	11,841	10,649	89.9	1,192	10.1
South Carolina	8,861	5,814	65.6	3,047	34.4
Rhode Island	8,065	3,889	48.2	4,176	51.8
New Hampshire	6,745	803	11.9	5,942	88.1
North Dakota	6,185	4,114	66.5	2,071	33.5
Idaho	4,489	3,942	87.8	547	12.2
Vermont	2,929	773	26.4	2,156	73.6
New Mexico	2,938	222	7.6	2,716	92.4
Delaware	2,597	701	27.0	1,896	73.0
Nevada	2,228	1,951	87.6	277	12.4
Wyoming	2,147	1,669	77.7	478	22.3
Puerto Rico	875	875	100	0	0

* Does not include ICF/MR ** Represents only Medicaid Beds

*** SNF's and ICF's are dually certified

II. Nursing home beds per 1,000 resident population 65 years of age and over, according to type of home, geographic division, and State: United States, 1971 and 1976

(Data are based on reporting by facilities)

Geographic division and State	1971			1976		
	Total	Nursing care	Personal care and other ¹	Total	Nursing care	Personal care and other ¹
Beds per 1,000 resident population						
United States -----	58.6	44.8	13.9	61.7	51.2	10.5
New England -----	73.3	58.4	14.9	74.0	57.3	16.7
Maine -----	63.7	46.6	17.2	71.0	51.7	19.3
New Hampshire -----	68.3	57.4	10.9	70.1	63.2	6.9
Vermont -----	62.7	47.1	15.6	96.8	55.9	40.9
Massachusetts ² -----	77.8	61.5	16.2	75.0	57.4	17.7
Rhode Island ² -----	62.0	45.7	16.3	63.2	50.9	12.3
Connecticut -----	74.5	62.8	11.7	74.2	60.1	14.2
Middle Atlantic -----	42.8	31.3	11.6	47.1	38.0	9.2
New York -----	41.3	29.5	11.8	50.7	37.7	13.0
New Jersey -----	43.5	31.7	11.8	43.1	36.0	7.1
Pennsylvania ² -----	44.8	33.8	11.1	44.1	39.4	4.7
East North Central -----	62.2	47.9	14.3	74.5	63.2	11.3
Ohio -----	59.0	46.5	12.5	59.5	53.4	6.1
Indiana -----	65.1	51.3	13.8	69.3	59.9	9.4
Illinois -----	60.7	40.3	20.4	75.2	63.2	12.0
Michigan ² -----	56.7	48.2	8.4	80.1	61.0	19.1
Wisconsin ² -----	78.4	64.5	13.9	100.5	90.4	10.2
West North Central -----	81.1	58.2	22.9	83.2	70.2	13.0
Minnesota ² -----	99.4	76.3	23.0	96.3	81.6	14.7
Iowa -----	96.0	63.5	32.5	91.8	73.7	18.1
Missouri ² -----	56.4	44.3	12.1	55.2	46.5	8.7
North Dakota -----	91.1	56.3	34.8	91.7	70.0	21.7
South Dakota -----	85.9	60.0	25.9	97.5	72.1	25.4
Nebraska ² -----	81.6	58.2	23.4	118.5	109.7	8.8
Kansas -----	81.0	52.5	28.5	80.3	70.7	9.6
South Atlantic -----	40.5	30.5	10.0	40.8	32.8	8.0
Delaware -----	41.7	28.9	12.8	42.8	36.5	6.3
Maryland -----	47.5	42.1	5.4	54.7	48.1	6.7
District of Columbia -----	39.6	29.1	10.5	40.5	31.8	8.7
Virginia ² -----	41.3	27.2	14.1	57.8	38.1	19.7
West Virginia -----	19.6	12.7	6.8	26.0	20.5	5.5
North Carolina ² -----	44.8	19.4	25.4	48.1	25.8	22.3
South Carolina -----	37.8	32.6	5.2	36.4	34.1	2.3
Georgia -----	60.2	54.0	6.2	66.5	65.4	1.1
Florida -----	33.8	27.4	6.4	23.9	21.0	2.9
East South Central -----	41.0	29.8	11.1	47.2	39.7	7.5
Kentucky ² -----	54.1	26.3	27.8	56.0	37.4	18.6
Tennessee -----	36.2	28.0	8.3	44.4	40.6	3.8
Alabama -----	39.9	37.2	2.6	50.4	45.7	4.7
Mississippi -----	31.1	27.5	3.5	34.8	32.8	2.0

See footnotes at end of table.

Source: Health: United States - 1979, U.S. DHEW, Office of Health Research, Statistics and Technology, 1980.

Table 63. Nursing home beds per 1,000 resident population 65 years of age and over, according to type of home, geographic division, and State: United States, 1971 and 1976--Continued

(Data are based on reporting by facilities)

Geographic division and State	1971			1976		
	Total	Nursing care	Personal care and other ¹	Total	Nursing care	Personal care and other ¹
Beds per 1,000 resident population						
West South Central -----	67.3	60.1	7.2	77.4	70.0	7.5
Arkansas -----	61.4	57.6	3.8	71.2	67.3	3.9
Louisiana -----	46.4	43.6	2.8	53.9	51.3	2.6
Oklahoma -----	87.6	79.6	8.0	78.2	74.4	3.7
Texas -----	69.0	59.9	9.1	85.6	74.7	10.9
Mountain -----	56.9	45.2	11.7	57.0	50.2	6.8
Montana -----	63.7	48.1	15.6	69.3	61.4	7.9
Idaho -----	55.9	51.0	4.9	59.5	49.1	10.4
Wyoming -----	54.7	43.8	10.9	56.6	45.5	11.1
Colorado ² -----	85.2	70.0	15.2	104.3	94.2	10.1
New Mexico -----	44.6	30.5	14.1	35.8	28.8	7.0
Arizona ² -----	30.0	26.2	3.8	25.0	23.0	2.0
Utah -----	59.6	39.2	20.5	48.6	42.3	6.2
Nevada -----	43.7	31.3	12.4	34.9	29.1	5.7
Pacific -----	79.1	57.9	21.3	67.0	52.3	14.7
Washington -----	86.6	69.9	16.7	80.9	71.1	9.8
Oregon -----	73.7	55.3	18.4	64.4	52.4	12.0
California -----	79.2	56.6	22.6	65.1	49.2	16.0
Alaska -----	93.3	68.3	25.0	86.9	76.7	10.2
Hawaii -----	48.7	34.9	13.8	53.1	42.1	11.1

¹ Includes personal care homes with nursing, personal care homes without nursing, and domiciliary care homes.

² The change from Federal to State data collection in these States may have introduced changes in data collection procedures coverage, definitions, and concepts between 1973 and 1976.

SOURCES: Division of Health Resources Utilization Statistics, National Center for Health Statistics: Unpublished data from the Master Facility Inventory; U.S. Bureau of the Census: Population estimates and projections. Current Population Reports, Series P-25, No. 734. Washington. U.S. Government Printing Office, Nov. 1978.

III. Nursing Home Reimbursement

SNF Reimbursement Rates

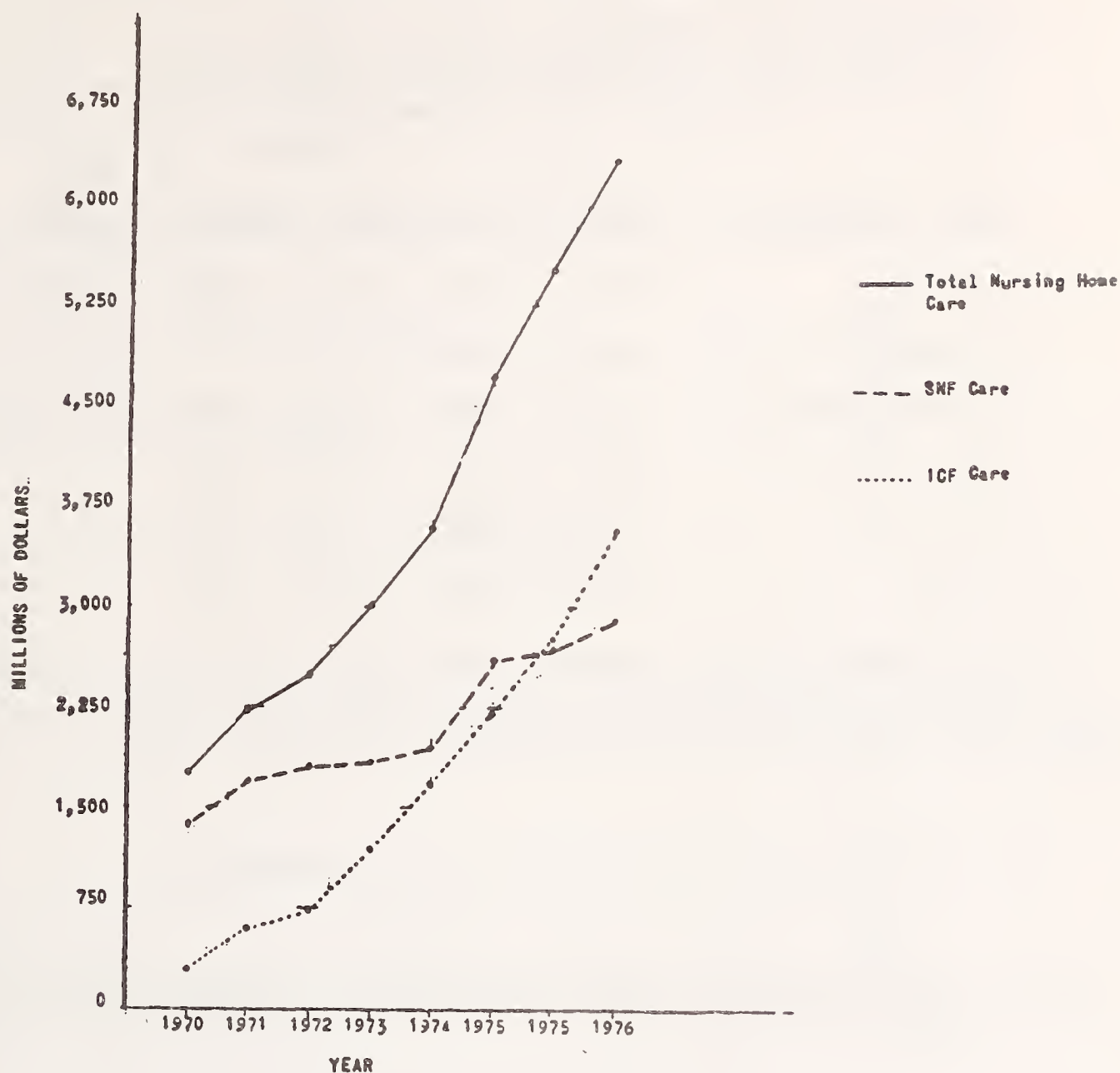


ICF Reimbursement Rates



IV. Medicaid Expenditures

Medicaid Expenditures for Nursing Home Care



Nursing Home Expenditures as a Percentage of Total MA Expenditures

	1970	1971	1972	1973	1974	1975	1976	1977
Skilled Nursing Care	25.8	25.8	23.1	21.0	20.0	20.1	18.2	17.2
Intermediate Care	5.9	8.3	9.6	13.2	15.8	17.7	19.5	22.0
Total Nursing Home Care	31.7	34.1	32.7	34.2	35.8	37.8	37.7	39.2

Source: Data on the Medicaid Program: Eligibility, Services, Expenditures, FY 1966-78,
 US DHEW, Health Care Financing Administration, Institute for Medicaid Management, 1978.

V. Personal Health Care Expenditures and Medicaid's Share of Expenditures (FY 76)
(Dollar amounts in millions)

<u>Personal Health Care Expenditures</u>						
Type of Service	Total	Private	Source of Funds		MA as % of Total	MA as % of Public
			Total	Medicaid		
Total	\$120,431	72,013	48,418	13,977	11.6	28.9
Hospital Care	55,400	25,004	30,396	4,446	8.0	14.6
Nursing Home Care	10,600	4,744	5,856	5,283	49.8	90.2
Physicians	26,350	19,718	6,632	1,356	5.1	20.4
Dentists	8,600	8,131	469	377	4.4	80.4
Drugs	11,168	10,144	1,023	936	8.4	91.5
All Other	8,313	4,272	4,042	1,579	19.0	39.1

Source: Data on the Medicaid Program: Eligibility, Services, Expenditures - FY 1966-78,
US DHEW, Health Care Financing Administration, Institute for Medicaid Management,
1978.

VI. Patient Assessment

A. Pre-admission Assessment: Institutional Long Term Care

Most states, 90% (28) require pre-admission assessments for institutional long term care. Seventy-five percent (75% or 21), however, only require these assessments for Medicaid patients. Comprehensive criteria, (e.g. social and environmental as well as medical factors), are used by 61% (17) of the states which require a patient assessment.

<u>Responsibility for performing assessment:</u>	<u>#</u>	<u>*%</u>
Discharging Institution	1	3.6
State Medicaid/Social Services Personnel	4	14.3
PSRO	7	25.0
Admitting Facility	1	3.6
Attending Physician	1	3.6
Combination of 2 or more of above	14	50.0

B. Pre-admission Assessment: Home Care

Most states, 68% (21) reported that pre-admission assessments are required for the provision of home care services. Of these, however, 57% (12) only require assessments for Medicaid patients. Comprehensive criteria, (e.g. social and environmental as well as medical factors), are used by 76% (16) of those states which require patient assessments.

<u>Responsibility for Assessments</u>	<u>#</u>	<u>*%</u>
State Medicaid/Social Services Personnel	3	14.3
Home Care Provider	8	38.1
Physician	1	4.8
Local Medicaid/Social Services Personnel	1	4.8
Combination of 2 or more of above	8	38.1

*Percentage of those states which require assessments

VII. State Projects To Provide Alternatives To Institutional Care: Sources of Funding

There are currently twenty-seventy projects in nineteen states, all in varying stages of development, which have been established to create alternatives to institutional long term care.

<u>State</u>	Funding				
	<u>SFF*</u>	Reg. Title XIX	State	SSI Payments	Title XX Other
New York - Project 1			x	x	
" 2	x	x	x		
" 3	x	x	x		
" 4	x	x	x		
Delaware					x
Puerto Rico		x.	x		
Vermont - Project 1		NOT AVAILABLE			
" 2		NOT AVAILABLE			
Maryland		NOT AVAILABLE			
New Jersey		x			
North Carolina	x				
Kentucky			x		
Michigan			x		x
Florida	x	x	x		
Texas	x	x	x	x	
South Carolina	x		x		x
Nebraska		x		x	x
Virginia					x
Arkansas				x	
Ohio	x	x	x	x	
Wisconsin			x	x	
New Mexico	x		x	x	x
Connecticut (5 projects)	x	x	x		

*Special Federal Funds - Section 1115 or Section 222 waiver projects

VIII. Recommended Federal Legislative/Regulatory Changes

The Long Term Care Survey asked states what changes they would propose in federal legislation and/or regulations to allow them to better meet the needs of their long term care populations. Most of the states indicated that incentives for institutional care must be eliminated; or conversely, incentives for the utilization of alternatives to institutionalization must be initiated.

Approximately 25% of the respondents suggested that FFP be introduced for lower-level facility care. Approximately 21% of states indicated that they would like the scope of reimbursable home health care services to be expanded. It was proposed by about 13% of the respondents that the FFP level for home health care services be increased.

In order to create incentives for home health care utilization, many states suggested mechanisms for increasing eligibility. It was recommended that the income level for home health care eligibility be increased to that of institutional care. Other proposals which would expand eligibility included: repealing the "homebound" and "skilled nursing" requirements of the Medicare program and eliminating Medicare's 3-day prior hospitalization requirement and 100 visit per year limit.

Approximately 8% of the states indicated that pre-admission reviews/assessments should be mandatory for all nursing home patients, including private pay patients. In addition, it was suggested that the personal needs allowance of institutionalized persons be raised.

Several states indicated cost concerns. Two states would like strict federal regulations requiring recoupment of transferred funds, and prohibiting the divestment of resources for the purpose of obtaining Medicaid eligibility. Another suggested a strict federal regulation requiring families to assume some responsibility for payment for care.

One state proposed that Titles XIX and XX be incorporated to provide a single program for long term care services with a separate funding mechanism.

Other proposals included: omitting age restrictions for persons receiving care in institutions for mental illness; clarifying residency requirements for out-of-state residents; requiring that all Title XIX facilities be dually certified for SNF and ICF level care; providing incentives for the development of comprehensive assessments and case-management and amending section 1108 of the Social Security Act which imposes a cap upon reimbursement for Puerto Rico, Guam, and the Virgin Islands.

Summary of State Recommendations

	<u>Number of Rec's.</u>	<u>Percent of all Rec's.</u>
Introduce FFP for care in a lower level facility	6	16.2
Expand scope of reimbursable services under HHC	5	13.5
Expand eligibility for HHC	6	16.2
Increase level FFP for HHC	4	8.1
Require pre-admission assessments for all NH patients	2	5.4
Prohibit transfer of funds to attain MA eligibility	2	5.4
Raise personal needs allowance of institutionalized persons	2	5.4
Other	11	29.7

Some of the recommendations made by the states are reflected in pending federal legislation. Medicare's 3-day prior hospitalization requirement and 100 visit per year limit would be eliminated if either H.R. 934 or H.R. 3990 were passed. H.R. 934 and an amendment to H.R. 4000 would prohibit the transfer of assets to obtain Medicaid eligibility. S. 1204 and H.R. 4000, include provisions to increase Medicaid funds to the territories: H.R. 6194, the Medicaid Community Care Act of 1980, would increase FFP for those states which adopt a comprehensive assessment process for persons in need of SNF or ICF level care. It would also provide Medicaid reimbursement for a wider range of home care services than is currently permitted. Legislation which has been proposed by Senator Packwood would create a Title XXI funding program for long term care services, incorporating existing long term care provisions of Titles XVIII, XIX and XX.

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